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# The Journal of Obstetrics and Gynæcology of the British Empire

VOL. XXVII. JANUARY, 1915. No. 1.


## A Note on the "Dublin Method" of Conducting the Third Stage in Labour.*


By T. PERCY C. KIRKPATRICK, M.D., M.R.I.A.,

*Fellow and Registrar of the Royal College of Physicians of Ireland.*


ON May 25, 1900, Dr. Henry Jellett made a communication to the Obstetric Section of the Royal Academy of Medicine in Ireland in which he set out to prove the following three propositions:—

"1. That the method of effecting the delivery of the placenta by external manipulations, as opposed to its manual removal or its delivery by traction on the funis, was originated in Dublin.

2. That Credé's method, when introduced *de novo* in Germany, was identical in principle with the Dublin Method, and it rapidly came to assimilate itself to the Dublin method in its most important details.

3. That, consequently, there is no difference between the Dublin method and Credé's method, and that inasmuch as the method originated in Dublin many years before the time that Credé discovered it for himself, its name is and ought to be 'The Dublin Method."[1]

Dr. Jellett appears to have proved quite satisfactorily his second proposition, and so much of the third proposition as depends on the second. With this matter, which is one for the decision of obstetricians, I do not feel competent, and do not propose, to deal. The first proposition and that part of the third which depends on it are, however, historical questions, and with your permission I should like to make a few observations concerning the conclusions at which Dr. Jellett arrived.

* A paper read at the Obstetrical Section of the Royal Academy of Medicine in Ireland on March 12, 1915.



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The first work on midwifery by an obstetrician of the Irish School was that published in Dublin by Fielding Ould, "Man-Midwife," early in 1742. In this work, which is entitled "A Treatise on Midwifery, in three parts," the following method is recommended for the management of the third stage of labour. "The Child, as was said before, must be laid on the Operator's Lap, or on the Bed, as far from the Mother as the Length of the Funis will admit; which he must take in the right Hand, about six Finger's Breadth from the Pudendum, and roul it twice or thrice about his Finger; then the first and second Fingers of the left Hand must be thrust into the Vagina, by its Direction; and the Patient stopping her Breath and forcing as if she were at Stool, the Navel-string must be gently pulled forward as she forces, the Operator rather waiting for her Expulsion of it, than being too desirous to extract it; for pulling the Funis so as to extract the Placenta forcibly, may probably cause a Flooding; or perhaps break the Navel-string whereby the Placenta would be very difficultly brought forth; therefore let him just pull it sufficiently to make it incline forward still insisting on the Patient's forcing down, which if she is not able to do of herself she must be compelled to it, by putting a Finger into her Throat, which will cause a Pressure of the Diaphragm, and the Muscles of the Belly, by her Efforts to vomit; by these Means it is commonly brought forth in about five Minutes. When it comes away by Expulsion, it is always whole, but it is subject to be broke, and Part of it left in the Womb, if any Violence be used for its Extraction.

"Most Authors give a strict Charge to lose no Time in the Extraction of this extraneous Body lest the Orifice of the Womb should contract and obstruct its Passage; and for this Reason they advise the Introduction of the Operator's Hand into the Matrix; and by insinuating the Fingers between it and the Placenta, to cause their Separation, the Manner of doing which, shall be presently described. This Fear of the Womb closing, makes many Operators too hasty, which often produceth fatal Accidents."[2]

Ould then proceeds to consider what these accidents are. The first is breaking of the Funis, which leads to "an immoderate Flux of Blood by the Umbilical Vein; the great difficulty of extracting the Placenta without its Direction and Assistance; the intollerable Pain caused by the (then necessary) Introduction of the Hand into the Womb, and the Danger of not removing the whole Substance entirely; and lastly, whatever Disorder the Patient may be subject to, during her Lying-in, will certainly be imputed to this Mischance."[3] The second danger is uterine hæmorrhage and the third "Prolapsus Uteri." Ould then proceeds to say "the Reason why we Operators run the Risque of

committing these Errors, is, lest the Orifice of the Womb should refuse a Passage to the Placenta, by its speedy Contraction. I shall therefore, endeavour to prove that the Orifice is not capable of so speedy a Contraction, as is generally imagined. It is universally allowed, that the Efforts of the Mother in the Time of Travail, tend chiefly to the Dilitation of the Orifice; it is also undeniable that these Efforts continue after the Child is born, untill the Expulsion of the Placenta is compleated; hence it follows, that till after this time the Orifice is incapable of absolute Contraction. Besides it is well known that the Placenta has often been extracted, one, two, or three Days after the Birth of the Child, when it has been left behind by some Malpractice of the Female Midwife; and this Extraction performed by the Introduction of the whole hand, through the Orifice into the Matrix. Hence it must follow, that if the Orifice be wide enough to receive the Hand, some Days after Birth, there certainly will be very little Danger of its closing in a Quarter of an Hour, so as to hinder the Expulsion of the Placenta. I shall beg the Reader's Leave to add one Circumstance more to confirm this Argument, which seems to put it beyond all Controversy; namely, that Nature designed its Expulsion by the Efforts of the Mother; which is proved by real Matter of Fact; for there are constant Instances of Women bringing forth Child and Burthen without any other Assistance than that of Nature. This happens chiefly to those who have Bastards, Women at Sea, and in Camps."[4] Next Ould considers the objections of Deventer "whose Authority has universal Approbation," and who "strenuously adviseth the constant Extraction of this Burthen by the Introduction of the Hand; and very much condemns the pulling it forth by the Funis." Deventer considered that the soft parts were so much dilated immediately after the birth of the child that the introduction of the hand did not cause pain, if it was done as soon as the child was born. Ould says the pain is caused by passing the hand through the bony inlet of the pelvis which does not dilate. Deventer said that there was a danger of the uterus contracting on the placenta "so that from a flat soft Cake, it become hard and oblong, and as it were contained in a Purse with running Strings drawn up tight about it." In reply Ould says "all this could not possibly happen in the longest Time that is necessary for its Expulsion; which, if it cannot be brought to pass in a reasonable Time, suppose ten Minutes, which perhaps does not happen to one Woman in five hundred, it is then time enough to put the miserable Patient to the Torture of introducing the Hand and thereby separating it from the Fundus Uteri."[5] Deventer had urged that the introduction of the hand into the uterus for the removal of the placenta had the further advantage of informing the practitioner "whether there be more Infants to come

forth; if there be a Mole or other extraneous body." Ould replies that this information can as well be obtained "by searching with two or three Fingers, immediately after Delivery." He further points out "that in the Expulsion of the Burthen, the Action is entirely in the Matrix, by means of the Diaphragm and abdominal Muscles pressing it, which forces out the Placenta as excrementitious; and as this Action is uniform, all Parts of the Placenta are equally pressed, therefore it comes out one intire equal Body, with its Surface next the Womb perfectly smooth; which shows that there is no Part of it left behind." With manual removal, on the other hand, parts of the Placenta are very apt to be left in the uterus. Finally he concludes as follows: "Though this Practice of Extraction must be condemned, as constantly used in natural Cases, yet where the Case is preternatural, it is absolutely necessary; namely, when by injudicious Management the Funis is broke; when the Patient is so weak as to be incapable of giving any Assistance, and that the Operator does not think it safe to depend on the Strength of the String; when the Child has been some Time dead, and the String thereby become rotten, and the Placenta corrupted; and besides these, in many other Circumstances that may occur to the prudent Operator; always observing, that it is better to depend on Nature, while there is any reasonable Hopes of Success, than too precipitately to have Recourse to Art."[6]

I have given these extracts from Ould's work at some length because on this work, I believe, the claim of the Dublin School to be the originator of the method of the management of the third stage of labour must stand or fall. On November 2, 1759, seventeen years after the publication of his Midwifery, Ould succeeded Moss as the second Master of the Dublin Lying-in Hospital, a post which he held for seven years, and though he lived till November 29, 1789, we have no record of any further writing by him on the subject of midwifery. The next Dublin Midwifery published was that by Edward Foster in 1781. Foster was Assistant Master to Ould's successor, William Collum, from 1772 to 1775. Foster does not give any clearer description of the Dublin Method than did Ould. Ould certainly recognized that a *vis a tergo* was useful in the delivery of the placenta, and further that its manual removal was open to serious objection, but he does not give up the traction on the funis, and nowhere can he be said to describe the "Dublin Method." The principles that he advocates were not originated by him for they appear to be older than the history of midwifery. Engelmann, writing on "Parturition among primitive People," says: "The placenta usually follows the child, but unless this is the case, massage and expression are invariably resorted to. It may again be remarked that primitive people, odd as it may seem, rarely pull on the cord, but in most instances use the *vis a tergo*,

stimulate the activity of the womb by friction of the fundus, and press out the contents. Massage combined with expression of various kinds, never very forcible, is used in this stage of labour."[7] Thus we see the practice of ancient and primitive people is nearer to the modern practice than that advocated by Ould.

In the year 1767, just a year after Ould's mastership terminated, John Harvie, M.D., Teacher of Midwifery, published in London a pamphlet of forty-eight pages with the following title: "Practical Directions, shewing A Method of preserving the Perinæum in Birth, and of Delivering the Placenta without Violence, illustrated by Cases."[8] This little pamphlet has lately come into my possession, and the description given in it of the method of conducting the third stage of labour seems well worthy of attention.

Harvie points out that there are two general methods of delivering the placenta. "The first, and perhaps the most general, method has been to deliver the placenta immediately after the child. To perform this, some have recommended an immediate introduction of the hand; others have advised pulling by the naval string; and some again say that the woman should be brought to sneeze, cough, or vomit. The second method is to leave this business principally to nature."[9] He objects to manual extraction on account of the pain caused to the patient, and on account of the damage that is likely to be done to the uterus. But even apart from this he dreads the "inflammation with the fever which it produces; a fever indeed so fatal that few survive it, though attended from the beginning by the most eminent and the most able physicians." He concludes "we may therefore flatter ourselves that this method will in time be entirely exploded, as I know it to be at present by a few of the most skilful in our profession." "Pulling on the umbilical cord to bring down the secundines" is, he says, "a practice, in my opinion, extremely dangerous, and likely to produce an inversion of the uterus."

Harvie proceeds then as follows. "Several authors have recommended, and I am sorry to say it is a most general practice, to make the patient sneeze, cough or vomit; and the last is even produced sometimes by making her smoke tobacco."[10] This plan he strongly objects to, and he states that he had seen one patient whose life for some days was endangered by uncontrollable vomiting induced in this way. Further by such convulsive efforts "the circulation is quickened, and at the same time the blood is with force expelled from the vessels of the uterus. Many women have been distroyed in half an hour by this loss of blood." He then goes on to show that the uterus will, if left to itself, almost always expel the placenta without danger to the patient. There may, however, be considerable delay, perhaps as much as three days, but such delay is not necessarily attended with danger. He says:

"My pupils, who deliver many poor women, according to my instructions, have, of late, left the delivery of the placenta to nature. In general, it comes away soon; but if, after waiting an hour, there is no unusual discharge, they order the woman to be carefully put to bed, and then leave her. In such cases, I have not known of any placenta that has remained longer than nineteen hours; and all the women thus treated, have recovered to great advantage."[11] This method he finds open to the objection that the women are more distressed and frightened by delay in the delivery of the placenta than in delivery of the child, and in consequence he makes the following recommendations: "In the following manner nature may be greatly assisted; and without any addition of pain. After the child is delivered, the navel-string tied, and the child given to the nurse's care, take the navel-string in your left hand, gently pull down its loose part, till you feel that it is a little tightened, and by it guide the fore-finger of your right hand; thus you will commonly feel that a part of the placenta is fallen into the os uteri, and often that portion of it, into which the navel-string is inserted. In either case by gently pressing the finger against the part felt, and continuing the pressure in the direction of the axis of the pelvis, that is, downwards and backwards, it will presently fall out of the uterus; and then it may be safely slipt out of the vagina, by the same finger . . . . There is another safe method of assisting nature in the delivery of the placenta, and which, for these five or six years past, I have found to answer generally very well in practice. As soon as the child is committed to the care of the nurse, let the accoucheur apply his hand on the belly of the woman, which is then very loose, and he will readily feel the contracting uterus: having then placed the flat of the hand over it, by a light and gentle pressure, bring it downwards, or towards the pubes, and he will feel the uterus sensibly contracting, and often feel it so reduced in size, as to be certain that the placenta is expelled. By this method we will seldom have anything to do afterwards, but to help it through the os externum, if even so much remains undone." "After the placenta is thus delivered, it may be advisable to apply the hand, as before, upon the belly; and if the uterus is found to be too large, the pressure cautiously repeated, will expel the greatest part of the coagula, which produced this increase of bulk."[12]

From these extracts we see that we have in Harvie's work, published in 1767, as clear and as exact a description of the management of the third stage of labour as was given in any Irish midwifery before the publication of McClintock and Hardy's work in 1848. Robert Wallace Johnson in his "New System of Midwifery," published in London in 1769, recommends Harvie's method and says: "I have used this method for some time; and have the pleasure to find the propriety of it confirmed by the

practice of Dr. Hunter and Dr. Harvie; the latter of whom, appears to have been the first who recommended it in his lectures." [13]

While then we give every credit to the Dublin School of Midwifery for its early recognition and consistent teaching of this method of conducting the third stage of labour we must, we fear, abandon the claim of its having originated that method. Dublin has a prior claim to Credé, but Harvie has a prior claim to both.

John Harvie was a man of some note in his time. He had married a niece of Smellie, and it was to him that Smellie handed over his lecture-room and the good-will of his class when he gave up practice and retired from London in 1759. It was John Harvie also that Smellie appointed joint executor with Mrs. Smellie of his will. To John Harvie and his wife came eventually the bulk of the Smellie property.[14]

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# Two Cases of Complete Chronic Inversion of the Uterus, Treated by Abdominal Section and Posterior Incision of the Uterus.

By J. Prescott Hedley, M.C. (Cantab.), M.R.C.P. (Lond.), F.R.C.S. (Eng.).

*Obstetric Physician with charge of out-patients to St. Thomas's Hospital.*

In a condition of such rarity it is remarkable that both these cases should have come under my care within a period of three weeks. They both started after labour at full term and were almost exactly similar in every detail.

I was struck by the completeness of the involution and the extreme mobility of the uterus in the vagina on its narrow attachment to the vault.

In both cases the vaginal portion of the cervix formed a collar round the stalk of the tumour, and was so soft that it was difficult to distinguish it from vaginal wall.

The operation performed in each case was very easy, and there was not the least difficulty in either in replacing the uterus after the incision in the cervix and lower uterine wall had been made.

Both patients did very well and were able to get up and to go home within three and a half weeks of their operations.

Case 1. Mrs. W., æt. 27, was admitted to St. Thomas's Hospital on December 30, 1912, suffering from metrorrhagia and leucorrhœa. She had had four children born at full term, all the labours were said to have been difficult and forceps had been used on each occasion; the first child died on the eleventh day after birth but the others were all alive and well.

The patient's health had always been good until her fourth confinement on July 31st, 1912. On that occasion, after the delivery of the child, the placenta was found to be adherent and had to be removed digitally, but the removal was said not to have been completed on account of bleeding. The patient lost a great deal of blood and was in consequence given intravenous saline.

She was in bed for six weeks after this confinement and had a thick yellow offensive discharge which was sometimes pink in colour; this discharge continued up to the time of her admission.

A month after getting up the patient began to have severe and frequent floodings for which she was ultimately sent to the hospital.

The blood was usually bright but sometimes dark clots were expelled. The bleeding was worse when the patient was about and doing her work, and in the intervals between the bleedings the yellow discharge was always present. She suffered from constant backache and frequent headaches but had had no fever or pelvic pain.

*Examination.* The patient was profoundly anæmic, the heart, lungs and urine were normal.

Nothing abnormal could be found on abdominal palpation; on vaginal examination a tumour, about the size of a hen's egg, was found occupying the vagina, it was pear-shaped with the larger end directed downwards and the smaller attached to the vaginal vault.

Around its attachment to the vaginal vault was a thin collar of tissue about half an inch in depth formed by the lips of the cervix.

Bi-manually no body of the uterus could be made out in the abdomen but when the patient was anæsthetised a depression corresponding to the inverted uterus could be felt.

The tumour was covered with thickened, dark red endometrium and was very freely movable in the vagina on its "stalk."

There was considerable bleeding on examination.

*Operation, January 1st,* 1913. I determined to try replacement by compressing and pushing up the uterus with one hand from the vagina while pressing downwards with the other hand through the abdominal wall on the outer margin of the cup formed by the inversion.

A prolonged attempt was made in this way without any success, then volsellum forceps were fixed onto the lips of the cervix and further attempts made by pressure on the fundus and traction on the cervix but with no improvement whatever.

During these manipulations there had been free bleeding and the patient, whose condition was not good at the beginning of the operation, began to show signs of shock. I thought it unwise to prolong the manipulations and therefore decided to open the abdomen and reduce the inversion either by pressure from below while the "ring" was under direct control from above or by division of the "ring" posteriorly to overcome the resistance.

When the abdomen was opened a ring was seen in the normal position of the cervix at its attachment to the vaginal walls just about large enough to admit the tip of the index finger, into which the Fallopian tubes and broad ligaments were drawn.

An attempt was made to reduce the inversion by pressure from below while steadying the "ring" with the hand above and also by traction with a volsellum forceps attached to the fundus at the bottom of the cup, but without any success. I then divided the

"ring" in the middle line posteriorly with scissors, one blade of which was passed about three-quarters of an inch into the cup, the other an equal distance along the posterior vaginal wall towards the floor of Douglas's pouch. The result of this incision was to divide in the mid-line the vaginal portion of the cervix, the upper three-quarters of an inch of the posterior vaginal wall and the posterior wall of the uterus for the same distance above the vaginal reflexion.

As soon as these tissues were divided my assistant was able immediately to reduce the inversion by very slight pressure from the vagina. The wound could then be seen in the lower part of the posterior wall of the uterus and the upper part of the vagina, but that in the vaginal portion of the cervix was hidden by the vaginal wall. The wound in the uterus was closed with catgut sutures from above downwards including the vaginal portion of the cervix, and then that in the vaginal wall was closed in the same way.

The bleeding, which was not great in amount, was quickly stopped by the sutures.

The peritoneum covering the uterus was roughened in places due to the attempted reduction of the inversion from above by the volsellum and not, as appeared at first sight, to adhesions.

After suturing the wound the uterus was flabby and fell back in the pelvis. I thought it possible that, in this position, adhesions might develop between the suture line and the structures behind it and bind down the uterus. In order to avoid this I did ventral fixation. The abdominal wound was closed with catgut for the deep layers and salmon gut for the skin.

The night of the operation the patient's temperature rose to 101·8° and the pulse rate to 140. She was given an injection of morphia.

For five nights after this the temperature rose to 100° but the pulse rate steadily diminished, and the patient's general condition rapidly improved. There was no pain or sickness.

The temperature remained normal after the sixth day and the wound healed by first intention.

The patient got up on January 19th and went home on the 24th.

I got a report from the patient's doctor on February 20, 1915.

The first period came on two months after the operation; it lasted for five days and there was great loss of blood. The second period was four weeks later and was much the same in amount as the first. Since then the periods have been normal and last for three days.

There has been no pregnancy since the operation, the patient's health has been very good, there is no anæmia, and she has not needed medical treatment.

CASE II. Mrs. D., æt. 32, was sent to me on January 18, 1913, on account of menorrhagia and metrorrhagia which she had had since the birth of her child. She had been married eight years and had had only the one pregnancy which ended at full term on July 8, 1912.

The birth of the child was normal, and a quarter of an hour later the placenta was expelled by pressure. Soon after this a tumour was seen in the vagina and within a few moments very severe bleeding started. The patient lost consciousness, the tumour was recognised as the inverted uterus and immediately replaced. After the birth the patient was kept in bed for three weeks, and during this time there was free bleeding every day. On getting up the loss became much more severe and continued for three months with very short intervals. After this the bleeding gradually diminished, but the periods were very profuse and lasted for ten days; between the periods there was always a good deal of yellow discharge and sometimes loss of blood.

There had been one attack of very severe pain in the pelvis three weeks after the birth of the child, but apart from this there had been no pain except bearing down, which had been noticed for some weeks before I saw the patient.

Ergot and other drugs had been given for three or four months to check the bleeding, and later iron pills.

*Examination.* The patient was extremely anæmic and had been an invalid since the birth of her child.

Nothing abnormal was found in the abdomen; the condition found on vaginal examination was exactly the same as in the previous case except that there was less bleeding on examination, the tumour was the same size, shape and colour, its lower end was equally freely movable in the vagina, and the collar surrounding its attachment was of equal depth.

I arranged for the patient to go into St. Thomas's Home and explained that the uterus could be replaced more or less slowly by continuous pressure or by a more rapid method in one operation which might entail an abdominal incision. The patient chose the latter as she was most anxious to avoid any prolonged method of reduction.

*Operation, January 20th.* Under the anæsthetic the ring corresponding to the inversion could be made out very clearly on bi-manual examination. For an hour and a quarter I attempted to reduce the inversion by pressure from the vagina, first while supporting the ring from above with the hand on the abdomen and later while drawing down the cervix with two or three volsellum forceps, but with no success.

During this part of the operation there was a good deal of

bleeding caused by handling the uterus and some tearing of the cervix by the volsellum forceps.

Having failed to reduce the inversion from below I opened the abdomen and did exactly the same operation as in the previous case except that I was able to replace the uterus quite easily by pressure on it through the bladder walls, in this way avoiding the drawbacks of making a vaginal examination while the abdomen was open. There were no signs of adhesions in the cup. I fixed the uterus to the abdominal wall with catgut and closed the deeper layers of the abdominal wall with silk.

After the operation the patient never caused me the least anxiety; there was no rise of temperature after the first evening, the wound healed by first intention, and the patient's general condition rapidly improved. She was able to get up on the sixteenth day and go home on the twenty-first.

A month later the patient wrote to me saying that she was very well indeed and able to walk miles.

I saw her on March 3rd, 1915, and she said that she had been perfectly well since the operation, the periods had been quite regular and normal in amount, and there had been no vaginal discharge. Recently there had been a slight return of the dysmenorrhœa that she used to have before the birth of the child.

The abdominal scar was sound. Per vaginam no scar could be felt in the posterior vaginal wall, but the incision in the posterior lip of the cervix had not united in its lowest part. The uterus was in good position, and nothing abnormal could be detected on bi-manual examination.

*Remarks.* In dealing with cases of complete chronic inversion there are two distinct methods of replacing the uterus that can be employed. The contracted cervix can be stretched and its resistance overcome by continuous pressure or the tissues that prevent reduction can be divided by incision. Stretching the cervix without any division of tissues is theoretically the better method as it causes less disturbance to the parts. When it can be done and the uterus replaced under an anæsthetic in a comparatively short space of time it is an ideal method, but unfortunately this is possible only in a small minority of cases.

More prolonged pressure can be exerted on the inverted uterus by the repositor and by this means reduction can usually be effected. There are, however, certain drawbacks to this method of treatment; it is slow, tedious and painful.

In cases of chronic inversion the patients are usually very anæmic and even careful examination of the uterus may cause free bleeding.

Often the contact of the repositor causes hæmorrhage, and as

the treatment may have to extend over several days the loss of blood may become serious; in some reported cases the treatment has had to be discontinued for a time for this reason. Finally the repositor may fail to replace the uterus.

The objections to incisions from the vagina, either in the anterior or the posterior wall of the uterus, are that the view of the operation field is poor, especially in the case of the posterior incision, there may be difficulty in stopping bleeding and in accurately suturing the wound in the uterus. A weak scar might result from this latter difficulty and give way in some subsequent pregnancy.

When the anterior incision is employed there is some danger of injuring the bladder.

Furthermore, both methods have been known to fail in effecting reduction of the inversion.

The objections to abdominal section and incision are that the operation may leave a weak scar in the uterus and that it is unnecessary to do so severe an operation for a condition that can be put right by the repositor.

With regard to the first objection I think the chances of danger in a subsequent labour resulting from this must be small, because the uterine wound can be seen and accurately sutured.

With regard to the second objection I feel that, in a difficult case at any rate, the repositor treatment is much more severe than an abdominal operation.

By opening the abdomen and dividing the uterus behind many of the disadvantages of the other methods are eliminated.

A long and painful treatment is avoided, the operation is easy and can be done quickly, bleeding can be controlled and the wound in the uterus accurately sutured. By this method failure to replace the uterus is reduced to a minimum.

When manual reduction has failed, I think the advantages of immediate reposition of the uterus more than counterbalance the drawbacks associated with an abdominal operation and therefore justify the method of treatment I employed in my two cases.

## Cases of Inversion of Uterus.

By R. Drummond Maxwell, M.D.

Cases of inversion of uterus warrant a clinical record for several reasons:—

(1) The extraordinary rarity. No cases have been admitted to the London Hospital for the last fifteen years.

(2) The divergent views expressed on the treatment of such cases.

(3) A tendency in modern literature to invoke surgical treatment as opposed to the classical treatment by reposition associated with the names of Aveling and Matthew Duncan.

Case 1. The first case referred to is of the "chronic" variety, and concerns a patient, aged 24, married two years, primigravida; seen by Dr. Lewers, July 1912. No special history was obtained from the patient. Instrumentally delivered under chloroform. The patient had no knowledge of third stage complications.

She was admitted owing to free hæmorrhage three days after labour. A mass the size of a fœtal head projected through the cervix into the vagina. There was no obvious sepsis; the uterine surface was clean; there was retention of urine, 35 oz. were drawn off by the catheter. The peritoneal "cup" of the inverted uterus was easily felt. Dr. Lewers saw the patient next day and tried manual reposition, but did not persist in this owing to severe pain caused thereby.

The hæmorrhage was checked in hospital during the next three or four days by repeated local douches. She was sent to a convalescent home fourteen days later, to come up again in a few weeks for further treatment. She did not, however, turn up until January 1913 (that is, four months' interval instead of one month), stating that she was fairly well until her period came on at the fourth month, and then she bled so freely that she became alarmed, and returned to hospital. On examination the involution was found to be fairly good, although the fundus was still as large as a golf ball, and projected for $2\frac{1}{2}$ in. into the vagina. Under chloroform Aveling's repositor was applied, with a large cup which fitted easily over the protruding fundus. It was left in overnight and taken out next morning. A considerable reduction of the inversion was noted. In forty hours' time, after five reapplications of the repositor, the fundus was now well within the cervical canal. To avoid difficulty in removal of the cup from the reinverted uterus a

smaller cup was used for the final stages, and its ascent carefully watched. In forty-three and a half hours from the commencement of these manipulations the uterus was found to be in its normal position. An interesting rise of temperature commenced from the day of final reposition of uterus, and lasted for eight days, varying between 103° F. and 99° F. This temperature gradually subsided, and the last three weeks of the patient's stay in hospital was apyrexial.

The patient has recently been heard of, and is in good health. No subsequent pregnancy has been recorded.

Case II. The second case is of the acute variety. The patient was admitted to hospital on October 21, 1914, with a very grave anæmia and serious flooding. She had been delivered three days before, and had been sent to hospital with the diagnosis of septicæmia. The patient's appearance and condition before vaginal examination were most suggestive of that diagnosis.

Details of the obstetric history are as follows: The patient, a primigravida, aged 24, had been delivered three days previously. Forceps had been applied. There was some difficulty in connection with the third stage. The placenta had not apparently been removed manually.

I examined the patient at 1 p.m. The bladder was emptied by catheter. A large mass was felt in the vagina and delivered externally. It was smooth over the greater part of the surface, but its lower pole was covered with necrotic tissue, fibrin, and placental shreds, which were still firmly adherent. There was intense fœtor, and very free hæmorrhage during examination. *Per abdomen* the peritoneal "cup" could be readily detected. It was impossible at first to get even a finger-tip from below through it. The inversion appeared to be "complete." From below, the uterine body, which was long and flask-shaped, narrowing at its neck to the calibre of a five-shilling piece, was firmly squeezed with hot towels to reduce its œdematous bulk. The foul clots and shreds were picked off the fundus, but it was difficult to determine the right plane of cleavage of the placental relics, and as this appeared to run rather too deep into the uterine wall further separation was not persisted in, and attempt at reduction was begun by pushing up a small portion at the side, and inverting it through the cup. One finger-tip carrying the lateral wall of the uterus in front of it was eventually felt *per abdomen*. This process was proceeded with all round the ring from below, till eventually four fingers pushed through the ring from below could easily be felt by the abdomen. The fundus of the uterus, which now lay about the level of the cervix, gave rise to little further difficulty. The complete reposition of the uterus from first to last took about forty minutes. A very considerable amount

of force had to be used at the start to dilate the ring from below, but once this had been effected no further difficulty was experienced. There was little shock on the whole following these manipulations.

The subsequent progress of the case was as follows: The patient stood the manual reposition well on the whole considering her profoundly debilitated condition. The next day there was naturally very considerable hypogastric tenderness, for the counter-pressure exerted from above had not been inconsiderable. Although the discharge from the uterus still remained reddened, there was at no time any further loss that could be considered severe. The discharge remained foul, though even this improved considerably with intra-uterine irrigation. Patient remained in a very weak exhausted state for the next seven days, and a diarrhœa, undoubtedly of toxic origin, retarded her convalescence. On the twelfth day the patient developed symptoms of a pulmonary embolism, sudden severe pain on the left side, crepitations, and rusty sputum. These signs were not progressive, and the patient still seemed to have a desperate chance of recovery till on the sixteenth day a sudden left hemiplegia occurred and she died in a few hours. A blood culture taken on the thirteenth day showed no positive growth of micro-organisms. The hemiplegia, in the absence of a post-mortem investigation, must therefore be attributed either to a thrombosis secondary to her anæmia or to cerebral embolism.

Several points of interest arise for discussion. It will be noticed that both cases were accompanied by retention of urine. This is remarkable, considering the fact that the bladder practically never shares in the displacement, though its anatomical relations with the uterus would rather lead one to believe that this would always occur. On the whole, I am inclined to attribute the retention of urine, certainly in the acute case, to collapse and exhaustion.

The points I would submit for discussion on the treatment of the acute case are two in number:—

(1) Is it advisable as a general procedure to attempt reduction of an acutely inverted uterus as late as twenty-four hours after this displacement has occurred?

In answer to this question, I would suggest that in my opinion, as a general rule, such treatment will not be wise, but a complicating factor, such as excessive bleeding from the tumour, may always confuse a clear decision on this point (as happened in my case). I felt I could not, with an easy conscience, abandon to expectant treatment a patient who had already suffered grave bleeding—and bleeding, moreover, which was still persisting in a lesser degree.

(2) Is manual reposition of an inverted uterus (in the acute

stage) indicated in the presence of septic metritic changes in its wall?

Were this the sole factor to be considered the answer would be, I think, quite definitely, that such manipulations are strongly contraindicated. But one of the unfortunate (or fortunate) considerations of so many urgent obstetric problems is that the accoucheur is left so much wiser after the event than before. Here was a uterus that appeared on the third day to be well-nigh strangulated. Its neck was narrowed down to the calibre of a five-shilling piece, and comprised in its circumference not only the cervical walls but the essential blood supply of the uterus in the broad ligaments. Perhaps I feared excessively a total necrosis of the lower pole of the uterus which would not have occurred, but in any case I am now convinced that, regarded from the point of view of septic uterine changes, the expectant attitude is the one that should have been adopted. That course has been followed out in a subsequent case admitted (under the care of my colleague, Dr. Russell Andrews) in the acute stage. Involution is, I believe, proceeding satisfactorily, and the patient will shortly be readmitted for reduction of the "chronic" displacement with Aveling's repositor.

It is a point of some interest to note that after an interval of close upon eighteen years three cases of the "acute" variety have been admitted in less than two years to the London Hospital. I believe on the whole that this displacement is not so rare as statistics would suggest, and that view is, I think, confirmed by the numbers of Fellows present to-night who have related their personal experience of the condition.

# Some Cases of Uterine Fibroid Associated with Pregnancy.[1]

By James Phillips, F.R.C.S.E.,
*Hon. Surgeon, Bradford Royal Infirmary.*

The following cases of uterine fibroids plus pregnancy are of interest chiefly as illustrations of the conditions which may call for surgical interference.

Pregnancy occurring in a uterus which contains one or more fibroids is a condition which renders the patient liable to a number of dangers either before, at, or after her confinement. So much is this so that some gynæcologists recommend hysterectomy whenever the condition is diagnosed. During the pregnancy the chief dangers are (1) miscarriage due to the fibroid interfering with the proper expansion of the uterus, and (2) red degeneration of the tumour with liability to infection of the degenerated growth. During labour there is danger of (1) obstruction to labour by impaction of a fibroid in the pelvis, (2) mechanical interference, by an intra-mural fibroid, with the normal muscular contraction, leading to delayed delivery, retained placenta or post partum hæmorrhage. In the puerperium infection of a degenerating fibroid is the chief danger.

We rarely have the opportunity to diagnose the presence of a fibroid prior to the onset of labour unless and until some complication arises as in the two following cases.

Case 1. Necrobiosis of Fibroid. Mrs. T., aged 33, came to see me on September 5th, 1914. Menses began at 15, always profuse. Married $6\frac{1}{2}$ years, has avoided pregnancy. Three years ago began to get attacks of colicky pain in the abdomen quite low down. Became costive; previously bowels rather loose. Gradually increasing dyspareunia. Lately a feeling as if something was in the vagina, noticed, *e.g.*, on sitting down. She decided to try whether pregnancy would relieve her symptoms and she became pregnant three months ago. Since then all her symptoms have been aggravated and frequent dysuria added. On examination the uterus was felt reaching half way to the umbilicus. P.V., cervix soft, placed high up and to the right. What appears to be a cervical fibroid growing into the right broad ligament and the size of a large pear, comes

1. A paper read at the meeting of the Bradford Medical-Chirurgical Society in February, 1915.

down to within two inches of the vulva. At the Bradford Royal Infirmary I opened her abdomen and was able to shell a fibroid out of the posterior wall of the uterus without disturbing the pregnancy. The pathologist reported the tumour to be undergoing red degeneration. The patient did well but would not rest after she left the infirmary and she aborted some 2½ months after the operation.

Case II. Suppuration in Fibroid. Miss B., æt. 37, was sent to the Bradford Royal Infirmary on August 2, 1914, with an abdominal tumour. Her doctor had first seen her ten days before and the tumour had got markedly larger in the course of a week. The patient had had three months' amenorrhœa and had suspected pregnancy. She was thin and obviously ill; temperature 101°, pulse 124. The abdomen showed a smooth, globular, tender, fixed, centrally placed tumour extending up to 1½ inches above the umbilicus and closely connected with the uterus, as made out on bimanual examination. The cervix was not conclusive of pregnancy. I thought the case was one of ovarian cyst with twisted pedicle. On opening the abdomen I came on adherent omentum. On freeing this pus poured out in quantity. The bowel was packed off and the tumour delivered and found to be a uterus with a large broken-down fundal fibroid riddled with suppurating tracks. Subtotal hysterectomy was rapidly performed, the peritoneal cavity mopped out, a large rubber tube put in and the abdomen closed.

On opening the uterus a three months' pregnancy was found, and there was pus about that part of the fœtal membranes which was in contact with the fibroid. The patient did well for a fortnight and then got intestinal obstruction from adhesions of small bowel to the pelvic scar. These were freed at a second cœliotomy after which she made an uninterrupted recovery.

A question (which would have been awkward from a medico-legal point of view had the patient died and which I must leave unsolved) is what was the source of the suppuration? Had the patient been using some infected instrument in an attempt at procuring abortion? Or had the pregnancy (as in Case I) interfered with the adequate blood supply of the fibroid and led to its degeneration and subsequent infection from the bowel?

In the other four cases the fibroid was not discovered until the pregnancy had terminated.

Case III. Necrobiosis during Puerperium. Mrs. A., aged 36, was delivered with forceps and made a good recovery until the 12th day when the temperature and pulse rate went up. The patient felt well, but for a fortnight the pulse kept over 100 and the temperature was never under 100° in the evening, and the fundus

uteri remained palpable above the pubes. An anæsthetic was given and on bimanual examination with a finger in the uterus a round mass some three inches in diameter was felt high up in the anterior uterine wall. The temperature came down to normal within a day of the examination and the pulse rate became steadily less. Operation was declined and the patient got quite well. Two years later she was delivered of a second child and made a perfectly normal recovery. Her second pregnancy and puerperium were watched by her medical attendant with some anxiety, but nothing abnormal occurred, nor was the tumour made out post partum.

Presumably it had become shrivelled and contracted as the result of the degeneration which followed the first pregnancy and had lost all power of growth.

Case iv. Sloughing of Fibroid during Puerperium. Mrs. K., who had previously had two normal confinements, was delivered on June 12, 1910, of an anencephalic monster. There was a marked degree of hydramnios, the uterus contracted badly, the placenta had to be removed manually, and there was some post partum hæmorrhage. In spite of this she was up and about in a fortnight, but a week later she sent for her doctor because she had pain and offensive vaginal discharge. I saw her on July 7th. She looked ill, her temperature was raised and her pulse quick. The abdomen was normal. P.V. the widely dilated cervix was found tightly surrounding a dark offensive globular mass as big as a man's fist. I thought this was an inverted uterus but on operating next day it turned out to be a sloughing fibroid which the uterus was in process of extruding. It was easily removed; the patient was soon quite well.

Case v. Malignant Change in Fibroid. Mrs. P., æt. 40, has had two children. The second child was born ten years ago and her doctor found a fibroid in the uterus at that time. When menstruation returned it was very profuse, and a year after the confinement she was curetted with temporary benefit. For nine months before I operated on her she had had almost daily bleeding with monthly exacerbations. The uterus, which was about the size of a large cocoanut, was removed on May 16, 1914. The microscopical report was: "Hæm-angio-endothelioma, malignancy probably only slight." The patient has remained well until now (February 1915).

Case vi. Puerperal Degeneration of Fibroid producing Intestinal Obstruction. Mrs. B., æt. 35, was confined on December 23, 1914. Her doctor found a fibroid in the anterior wall of the uterus

at the time. The puerperium was normal, save for rather more abdominal pain than usual, until the early morning of December 31st when she vomited and the nurse found that the abdomen had become suddenly and markedly distended. An enema was given; no motion was passed but a good deal of flatus. The same result followed a second enema in the late afternoon. When I saw her at 9 p.m. the patient did not look ill and had little pain and was not sick. The temperature was normal; the pulse rate 110. There was very considerable tympanitic abdominal distension and some slight general tenderness. P.V. nothing abnormal was made out and the uterus was apparently involuting well. On opening the abdomen coils of small bowel were found adherent to a fibroid in the anterior uterine wall. It was as big as a cricket ball and of greyish-yellow colour, "boggy" in consistence, and its peritoneal coat disintegrated in places. There was some opaque odourless fluid in the neighbourhood. The adherent bowel was separated and subtotal hysterectomy performed. She made an excellent recovery, save for the occurrence of a small anal abscess in connection with an inflamed pile which had to be incised on the 8th day after the operation. She was sitting out of bed less than three weeks after the hysterectomy had been done and was soon quite well.

If I were asked to lay down guiding principles for the treatment of cases in which pregnancy is associated with fibroids, I think I should say something like this. Many patients with fibroids have perfectly normal pregnancies, labours and puerperia and therefore I cannot agree that hysterectomy is advisable in every case. I recently removed a fibroid from a woman aged 48 who had had nine living children.

If a pregnant woman is known to have a fibroid she should be warned that its presence adds very definitely to the dangers of her condition and throughout the pregnancy she should be under observation. Should the local and general symptoms point to degeneration of the fibroid a laparotomy should be done; as in Case I, a myomectomy may be possible but in most cases hysterectomy will be required.

If the tumour seems from its position to be likely to obstruct labour it may either be attacked early on, or the position explained to the patient and operation postponed until a viable child exists, when a Cæsarean section plus hysterectomy may be performed. The risks of this operation are not materially greater than those of a hysterectomy performed a month or two earlier and many women, when they understand that this is practically certainly the only chance they will ever have of giving birth to a living child, will choose to go on until near term.

If the fibroid is causing no symptoms and is not placed where

it is likely to block the pelvis, the probability is that the labour will proceed more or less normally. The uterine contractions may be interfered with by the tumour, the first stage will probably be somewhat slow, instrumental help is more likely to be needed than if there were no fibroid, and I have had to remove the placenta manually in more than one case of this kind owing to the fibroid having interrupted the normal retraction of the uterus.

If the patient gets over the labour and the puerperium, what then? In the majority of cases I think operation should be advised. The last four cases illustrate some of the dangers of leaving a fibroid behind. Altered blood supply is more than likely to produce degenerative changes in the tumour, either necrobiotic or gangrenous. If the patient escapes this danger, the ordinary risks of a fibroid, such as excessive bleeding, remain and, as in Case V, the growth may become malignant.

It by no means follows that hysterectomy will be required. A fibroid which has permitted a pregnancy to proceed to term is likely to be nearer the serous than the mucous surface of the uterine wall and, if single, may be enucleated with ease and safety. The former fear of myomectomy is giving place to the conviction expressed by Christopher Martin in his Ingleby Lecture that myomectomy is the ideal treatment of uterine fibroids, and with increasing experience the proportion of cases so treated is likely to increase steadily.

# A Case of Tubercular Salpingitis with Unusual Toxic Symptoms.

By Gibbon FitzGibbon, M.D., F.R.C.P.I.
*Gynæcologist, Royal City of Dublin Hospital.*

The following case is of interest from the fact that the chief symptoms of which the patient complained were evidently due to the toxic effect of the disease upon the eyes and nerves of the arms and legs, while there was a complete absence of symptoms pointing to the pelvic organs. The case was referred to me by Dr. C. E. FitzGerald on the chance of discovering some source of toxins which would account for the symptoms.

*History of the case supplied by Dr. FitzGerald.* "Miss M. first consulted me about her sight in February 1912, complaining of fatigue and distress in her eyes when reading. I prescribed glasses which relieved her. The following month the left eye became attacked with irido-cyclitis which gradually produced a serious impairment of the vision, so much so, that after some time she was only able to count fingers at four metres distance. Under treatment some improvement of the vision took place, but relapses constantly recurred. No cause could be found to account for the attack except that at times she complained of what seemed to be rheumatic pains chiefly in her arm. At such times the vision appeared to be always more affected. There were numerous streaks and floating opacities in the vitreous. The vision of the right eye remained remarkably good, but in February 1914, the patient noticed some dimness in it, and stated that a few days before this it had been slightly inflamed. From the appearance it presented it was evident she was threatened with an attack of irido-cyclitis, though not of so severe a character as that of the left eye. She complained of pain in the eye, arm, and knee. At my suggestion she made arrangements to go for a course of treatment to Bath. The physician whom she consulted there advised her to see an oculist and this gentleman wrote to me later to say that in his opinion the case was syphilitic and advised a course of potassium iodide. As I had had her on this drug for several months, had also given her mercury and had gone very carefully into the history of the case, I felt quite satisfied there was no evidence to justify this diagnosis. In order to make sure, however, I asked Mr. Henry Moore to examine the case. He applied the Wassermann test which was absolutely negative, and he could find no trace of syphilitic infection."

On the suggestion of Dr. Moore the case was referred to me, Miss M., æt. 37, single, and I made a rectal examination. I found the pelvis completely blocked up with a firm mass extending out towards the sides and filling Douglas's pouch, irregular in outline and pushing the uterus forwards. There was no history of any abnormality in menstruation nor of any pain. The diagnosis of tubercular tubes was made and on April 29th, 1914, I did a laparotomy. Both tubes were found enlarged to about the size of hen's eggs, and everything closely matted and densely adherent. In order to remove the disease it was necessary to dissect from the left side across the pelvis through the uterus and then shell the whole mass out, which was densely adherent to both the bladder and rectum, and both of which organs were opened in the process of separating the diseased mass. The patient made an uninterrupted recovery and left hospital three weeks later. From the third day after the operation the pains in the arm and leg completely disappeared, and at the time of leaving hospital the sight had improved. A further note from Dr. FitzGerald in October 1914, says: "So far the operation has proved most satisfactory. The vision of the left eye which, before the operation, had been reduced to $^1/_6$ of the normal standard is now practically $\frac{1}{3}$, and the vitreous opacities have cleared up in quite a remarkable manner. The vision of the right eye, though not quite so good for distance as it was shortly after the operation, is very distinctly better for reading, in fact, when tested the patient was able, with her correcting glasses, to read the smallest test type wonderfully well."

The patient since the operation has put up weight and looks extremely healthy; she has resumed her work since September and been able to carry it out, having previously had to give it up on account of her sight and the pain it caused her in her eyes.

Apparently the symptoms in the case were due to the action of the toxins formed in the pelvis, the most serious effect being upon the eyes and tending to produce total loss of vision, while the pains in the limbs were probably neuritis due to the same cause.

## A Fatal Case of Rupture of the Uterus.*

By W. E. Fothergill (Manchester).

This case is described in order to put on record an example of the very extensive injuries which may sometimes be observed in cases of rupture of the uterus.

The patient, E.B., was 41 years of age. She had had nine previous confinements, the first 18 years ago and the last five years ago; also five abortions, the first 16 years ago and the last $4\frac{1}{2}$ years ago. She last menstruated in March, 1914.

On December 1 the patient was delivered at her own home by her own doctor. Version was performed because the lie of the child was transverse. When removing the placenta the medical man felt a rent in the uterine wall on the right side. He emptied the uterus, and sent the patient to St. Mary's Hospital in the evening.

On admission she was collapsed and had lost a large amount of blood. Hæmorrhage from the vagina continued to be excessive. The pulse rate was 144. When I saw the patient a little later the pulse could not be felt at the wrist and she was gasping. The lower abdomen was tender but not rigid, the abdominal wall moved with respiration, there was no urine in the bladder, and vaginal bleeding still continued. The abdomen was opened without delay, and, as the incision neared the pubic symphysis, it was seen that the lower part of the abdominal wall contained much extravasated blood. The abdominal cavity did not contain any great quantity of free blood. The tear through the peritoneum extended forward on the right of the bladder on to the anterior abdominal wall. It extended backward very nearly to the lower pole of the right kidney. The bladder was bare and separated from the adjacent structures except over the trigone and the lower part of its left lateral aspect. The uterus remained attached on the left side, but the cervix and lower uterine segment on the right side were represented by blood clot and shreds of tissue. The right uterine artery was not seen, nor was the ureter. The cæcum and appendix vermiformis with the adjacent portions of the large and small bowel were torn from their bed; and the hæmatoma extended on to the abdominal wall far past the outer limit of the infundibulo-pelvic ligament. After cutting through the left broad ligament and round

* Read before the January meeting of the *North of England Obstetrical and Gynæcological Society*.

ligament and the left half of the cervix, the uterus came away in the hand, and its removal was completed by dividing the right round ligament and a fragment of the right infundibulo-pelvic ligament which remained untorn. The peritoneum was drawn together as well as possible, and a gauze drain was placed over the seat of injury and left *in situ* for 48 hours.

The patient rallied gradually. She passed no urine for 24 hours, but on the fourth day she passed 33 ounces naturally. The pulse rate slowed to about 100 on the second day and maintained that rate until the middle of the fourth day. The temperature was normal on the second and third days, but rose on the fourth morning. There were rigors on the fourth evening and on the fifth morning. The bowels were well moved on the second, third, fourth and fifth days by enema. Death occurred during the afternoon of the sixth day.

At the autopsy there was found a well shut off abscess cavity in the pelvis, but no general peritonitis, though pus tracked upwards towards both kidneys behind the peritoneum. The bladder was uninjured. The right ureter was not traced through the lacerated area. The cæcum and appendix were normal.

As version had been done and as the placenta was removed by hand, it is not surprising that the lacerated wound was infected in this case. But, apart from infection, this patient appears to have had a chance of life in spite of the very extensive and serious nature of the injury. Experience indeed shows that about two-thirds of the really serious cases of rupture of the uterus can be saved by prompt abdominal hysterectomy. That this is the proper treatment has long been recognised by the members of this society. So far as St. Mary's Hospital is concerned, I think the first of these operations was done by Dr. Walls in 1905. Including this case, the members of our Staff have now done the operation 17 times, with five deaths and 12 recoveries. In my own opinion all these 17 cases would have been lost but for the removal of the lacerated organ.

# REVIEWS OF CURRENT LITERATURE.

UNDER CHARGE OF EARDLEY HOLLAND, M.D.

## Surgery, Gynæcology and Obstetrics.

xix, 2, *June*, 1914.

1. The diagnosis and surgical technique to be employed in the handling of acute abdominal conditions; illustrating many interesting points in diagnosis and technique with original drawings. JOHN YOUNG BROWN.
2. Calculous anuria, with report of two cases. LINCOLN DAVIS.
3. *Final results (after five years) in 192 patients operated upon for ectopic pregnancy; with special reference to subsequent uterine and repeated ectopic pregnancies. RICHARD R. SMITH.
4. Excision of the clavicle and first rib for malignant disease. R. E. FORT.
5. Original surgical uses of the bone-graft. A report of two hundred and fifty cases. FRED H. ALBEE.
6. Composite or fibro-epithelial tumours of the lips. WALTON MARTIN.
7. *An improved Gilliam operation for uterine displacements. WM. CUTHBERTSON.
8. The educational value of cancer statistics to insurance companies, the public and the medical profession. FREDERICK L. HOFFMAN.
9. Death of a full-term fœtus due to constriction of the umbilical cord by amniotic bands; rupture of amnion; hydramnios. EUGENE CARY.
10. Clinical and experimental results of streptococcic infections with special reference to arthritis and its treatment. FREDERICK G. DYAS.
11. The röntgen findings in gastric and duodenal ulcer. JAMES T. CASE.
12. Treament of fractures by medullary bone splints. CHARLES DAVISON.
13. A new self-retaining abdominal retractor and wound protector. U. C. BATES.
14. Present status of joint diseases and best method of treatment. EMIL G. BECK.
15. X-ray findings in the normal stomach. ADOLPH HARTUNG.
16. Varicocele operations. WELLER VAN HOOK.
17. A clamp intended to facilitate the suture-anastomosis of hollow viscera. WILLARD BARTLETT.
18. Amniotic membrane for the prevention of post-operative peritoneal adhesions. A preliminary note. C. B. LYMAN and W. H. BERGTOLD.
19. The electric drill, saw, reamer, and trephine in bone surgery. CHARLES GEIGER.
20. Anæsthesia in surgical research. BERNARD FRANCIS MCGRATH.
21. Pituitrin in intestinal paresis following abdominal operations. O. H. STANLEY.

**Final results (after five years) in 192 patients operated upon for ectopic pregnancy.** In order to learn what becomes of patients operated on for ectopic pregnancy, with the main idea of being able to establish a more rational basis of judgment as to whether, in any given case, at the

time of operation, the opposite tube should or should not be removed, Smith has been in correspondence with a number of American surgeons; from those who were able to give him satisfactory statistics he has been able to collect the accounts of 192 patients operated on more than five years ago. A good deal of uncertainty exists as to the future course of ectopic pregnancy patients after their recovery from operation, particularly as to the frequency of subsequent normal pregnancies or repeated ectopic ones. In gathering statistics for a former paper on repeated ectopic pregnancy (*Am. Jnl. Obst.*, 1911, lxiv, 401), Smith found that out of 2,998 cases gathered from American hospitals there had been 113 recurrences, or 3.8 per cent. It was evident that this estimate was too low: first, because in large cities with a moving population it is almost impossible to follow patients for any length of time; second, no allowance was made for the nature of the operation performed; third, the age and civil condition of the patient afterwards were not considered; and fourth, the very important factor of lapse of time after the operation was entirely left out of account.

The 192 cases, on which the present paper is based, fulfil all the conditions for the drawing of accurate conclusions. In each case Smith received from the surgeon the date of the operation, the age and civil condition at the time of operation, the condition of the affected tube and what was done with it, and of the unaffected tube and how it was disposed of; the civil condition following operation was also noted, and their present state of health, and whether they had had any pelvic condition necessitating further operation; the facts as to subsequent uterine pregnancies, and whether there have been repeated ectopic ones, have been accurately obtained. All the cases were operated on five years ago or more. Of the 192 cases 48 had operations of a nature to preclude further pregnancies, or had already had the other tube removed; 12 had hysterectomies; 31 had the opposite tube removed; in three the opposite tube had previously been removed; one had the distal end of the opposite tube removed for hydrosalpinx; and one had the opposite tube ligated but not removed. This leaves 144 in which subsequent pregnancy was conceivably possible. Forty-seven of these women have had uterine pregnancies, or 32.6 per cent. (42 with living children, 64 children in all; one still-born, five aborting without children, five had abortions and children), 97 had none. There were 21 cases of repeated ectopic pregnancy, half as many as had living children. Two women had subsequent children and a repeated ectopic. Of the 67 women under 30 years of age 27 had subsequent uterine pregnancies, 10 had a repeated ectopic. Of the 74 women above 30, 19 had subsequent uterine pregnancy, and 11 had a repeated ectopic.

With these figures before him, Smith propounds the question as to whether, in cases of operation for ectopic pregnancy, the opposite tube, when it seems capable of transmitting the ovum, should be saved or removed. Each man must answer the question for himself, according to his convictions on the matter of preserving the childbearing function and the seriousness that he attaches to a further ectopic pregnancy. In young women the desirability of preserving the child-bearing function is of the greatest importance; in time and with the advent of children this desirability ordinarily diminishes. The age of the patient, the number of children she has borne, her general health, and her wishes as to further pregnancies, should all enter into the decision. Personally, Smith is now removing the opposite tube in women in whom, for reasons suggested above, childbearing is no longer important; in others, he is preserving it.

**An improved Gilliam operation for uterine displacements.** Cuthbertson describes a single new point, in the technique of Gilliam's operation, which aims at a firmer fixation of the two loops of the round ligaments in the abdominal wall. The aponeurosis of the external oblique is seized with a snub-nosed forceps, and with a scalpel a strip of the aponeurosis is peeled up from just above Poupart's ligament to a point about 2 cm. above where the round ligament loop emerges from the rectus muscle. Next, a sharp-pointed pair of Kocher's forceps is pushed through the loop, and, catching the aponeurotic strip, it is drawn down into place again and stitched there with a continuous catgut suture. Interrupted catgut sutures are placed through the round ligament and fascia to hold the ligament in its new position until the strip of aponeurosis shall have grown into place. By this means the round ligament is permanently prevented from slipping or being pulled back into the abdominal cavity, and the uterus is absolutely held in its normal position. The text of the description is illustrated by figures.

xix, No. 2, *August*, 1914.

1. Fractures near joints. HARRY M. SHERMAN.
   Fractures into joints. HARRY M. SHERMAN and DUDLEY TAIT.
2. Tumours of the neck. F. E. MCKENTY.
3. A case of common ileocolic mesentery with torsion. CAI TAGE-HANSEN.
4. Tuberculosis of the kidney; with especial reference to its diagnosis. GLEN EDRIE MACKLEM.
5. Operative treatment of aneurism of the aorta. H. KUMMELL.
6. Dysmenorrhœa essentialis. THEODORE J. DOEDERLEIN.
7. Calcified fibroma uteri compressing the sigmoid colon. GEORGE DE TARNOWSKY.
8. Traumatic parosteal bone and callus formation. OLIVER J. FAY.
9. Infraction of the second metatarsal bone. ALBERT H. FREIBERG.
10. Congenital contractures of the fingers; with the report of a case of the familial type. HAROLD NEUHOF and EDGAR D. OPPENHEIMER.
11. Modern war surgery. RICHARD J. BEHAN.
12. Contractured psoas parvus tendons; their insignificance and clinical relationship to lesions of the right iliac region. T. L. MACDONALD.
13. *Sarcoma of the round ligament of the uterus. FRED J. TAUSSIG.
14. A procedure for the repair of accidental injuries to the rectum. CHARLES GORDON HEYD.
15. On the technique of intrathoracic operations. ALEXIS CARREL.
16. Avulsion of the scalp. ARTHUR AYER LAW.
17. Anterior choledojejunostomy; with report of a case. REGINALD H. JACKSON.
18. A new method of circumcision. W. LAWSON THORNTON.
19. The further development of an apparatus for the transfusion of blood. HENRY S. SATTERLEE and RANSOM S. HOOKER.
20. The use of pituitary extract in labour. D. G. MADILL and R. M. ALLAN.
21. The axillary sup. GEORGE S. FOSTER.

**Sarcoma of the round ligament of the uterus.** In 1903 Emanuel wrote a thorough review of tumours of the round ligament. Taussig, in the present paper, reviews the literature of the last ten years to see what light, if any, the additional cases recorded during that period might throw on the pathology and symptology of this condition. He also describes a case of his own, of spindle-celled sarcoma of the round ligament. Taussig has added

61 new cases to Emanuel's original 80. The most interesting feature of these tumours is their varied pathology. In 135 out of the 141, a statement was given as to the nature of the neoplasm. Seventy-nine of them belonged to the group of fibromyomata: some of these were simply classed as fibromata and others as myomata. In 19 tumours there was only a thin shell of muscular tissue surrounding a cyst, and three of these cysts contained blood and were classed as hæmatomata. Occasionally the cysts were multilocular. One unique case is recorded of a dermoid cyst springing from the left round ligament. A striking fact is the comparative frequency of adenomyomata, the proportion out of all round ligament tumours being 22 per cent. There are six cases of sarcoma, including Taussig's own case. In general these round ligament sarcomata may be described as slow growing, and but slightly malignant clinically. Metastases are nowhere described, nor is there any record of recurrences after operation. In all but his own case the tumours were apparently malignant degenerations of a fibromyoma. Microscopic examination of the tumour in his own case gave no evidence of any previously existing benign tumour. There is a full list of references to the literature.

## Revue de Gynécologie et de Chirurgie Abdominale.

*May*, 1914.

1. *On mobilising the rectum when repairing a complete rupture of the perineum. S. Pozzi.
2. On ureterorrhaphy for section of the ureter. P. Sejournet.
3. Hydro-therapy in gynæcology. S. Pozzi.
4. *Fibroma of the broad ligament occurring with uterine fibroids. Xavier Bender.

**Fibroma of the broad ligament occurring with uterine fibroids.** Xavier Bender records a case occurring in a patient 44 years of age. The symptoms were mainly those due to the uterine fibroid. The patient had tried electrical and thermal treatments without success. He therefore removed the uterus and the tumour together with the ovary and tube on the same side. Sections were cut, which showed the broad ligament tumour to be a fibro-myoma and that it was entirely separate from the uterus.

**Mobilisation of the rectum when repairing a complete rupture of the perineum.** Professor Pozzi gives full details of his method of performing a complete perineorrhaphy and gives illustrations showing the results obtained some years after operation. He points out that any technique which includes putting sub-mucous sutures into the rectal wall is always attended by a risk of them becoming infected and working out. The method that he adopts consists of first making the usual H-shaped incision with the cross piece of the H corresponding to the junction of rectal and vaginal mucous membranes. This is then deepened till the anterior wall of the rectum is laid bare—this must be done very thoroughly so that the lower edge of the torn part can be pulled down as far as the position of the anus. If it is thus pulled on the wound assumes a quadrilateral shape, the upper margin being formed by the cut edge of vaginal mucosa and the lower by the pulled-on edge of rectum. The sides are formed by the skin of the future perineum. The remains of the levator ani are now brought across with catgut stitches, and deep sutures of silver wire passed to bring the perineal flaps together. Several illustrations show the various steps of

the operation. Professor Pozzi does not claim anything new about the method that he describes, as he has been doing the operation since 1892, but he has not yet printed a full description and therefore now publishes it. As regards after-treatment he keeps the bowels constipated for the first four days after the operation. He devotes some space to proving that he was the first operator to point out the importance of getting the rectum properly free and finishes with some details of clinical cases.

C. WHITE.

## Zentrallblatt für Gynäkologie.

No. 26, *June* 27, 1914.

1. Vicarious menstruation. A. HIRSCHBERG.
2. Imitative effects of röntgen rays and their therapeutic use in chlorosis. M. FRAENKEL.
3. Bayonet-shaped uterine sound. FLATAU.

Collections of abstracts from recent literature :—

Urinary organs.
Bowel.
Breast.
Fœtus and new-born.

No. 27, *July* 4, 1914.

1. *Radium treatment of cancer of uterus. F. SCHAUTA.
2. Diagnosis by post-anal palpation. SCHWARZENBACH.
3. Bayonet-shaped uterine sound. ENGELMANN.

Collections of abstracts from recent literature :—

Radiotherapy.
Physical treatment.
Vulva and vagina.
Fibroids.
Abderhalden's reaction.

**Radium treatment of cancer of the uterus.** The cases in Schauta's clinic can be arranged under three headings according to the method of treatment employed. *The first group* received continuous radiation for 3–11 days with 50–150 mg. of mesothorium. They all died, severe constitutional symptoms, diarrhœa, vomiting, etc., setting in. Examination, however, showed entire absence of cancer cells in the pelvis. *The second group* received intermittent treatment with the same dosage. These also showed untoward symptoms until the dosage was lowered. *The third group* received intermittent treatment with even smaller doses—30–50 mg. Of 22 cases belonging to the second and third groups, in all of which operation was contra-indicated, 11, *i.e.*, 50 per cent., are still alive and free from local recurrence. Schauta advises operation in all suitable cases, operation being followed with radium treatment.

No. 28, *July* 11, 1914.

1. *A new method of ovariotomy. H. FREUND.
2. Chorea gravidarum. W. KOLDE.
3. Differentiation between maternal and fœtal blood-stains. P. PERAZZI.

Collections of abstracts from recent literature :—

Extra-uterine pregnancy.
The pelvis.
Ovary and tube.
Abortion.

**A new method of ovariotomy.** Freund endeavours where possible, and especially in bilateral ovariotomies for non-malignant cysts, to leave behind a piece of ovarian tissue. Usually the ovarian rest lies at the attachment of the pedicle. He opens the cyst, feels and looks for the ovarian rest, and if near the pedicle he cuts round it, if at some distance he separates and transplants it on to the pedicle. G. G. ALDERSON.

## Monatsschrift für Geburtshülfe und Gynäkologie.

xl, 1, *July*, 1914.

1. Experiments on the effect of pituitrin on uterine contractions during labour. M. MALINOWSKY.
2. Treatment of extra-uterine pregnancy. J. OLOW.
3. Chorio-angioma. O. NEBESKY.
4. Quadruplets. E. BRATTSTRÖM.
5. Primary carcinoma of the Bartholin glands. J. FABRICIUS.
6. Italian obstetrical and gynæcological literature, 1912-13. P. HUSSY.
7. Russian gynæcological literature, 1913. W. BECKMANN.
8. Obstetrical and gynæcological theses of the German Universities. Winter session 1913-14. R. M. ALLAN.

## Gynækologische Rundschau.

Heft 11, 1914.

1. Symphysiotomy. K. HARTMANN.
2. Indications and contra-indications of pituitary extract in obstetrics. P. GALL. R. M. ALLAN.

viii, Heft 12, 1914.

1. *The treatment of atonic post-partum hæmorrhage. L. PISKACEK.
2. Resection of the ureters and after-treatment. K. FRANKENSTEIN.
3. Ovarian tumours and cysts. B. EHRLICH.

**The treatment of atonic post-partum hæmorrhage.** The author describes three methods of compressing the uterus externally in cases of atonic hæmorrhage after expulsion of the placenta. In the first the fundus and body as far as the retraction ring are gripped antero-posteriorly by one hand and the uterus pulled upwards. The other hand grasps the lower uterine segment transversely controlling the uterine vessels. The fundus is flexed forwards and vigorously massaged. In the other methods the fundus is grasped antero-posteriorly by both hands, pulled well upwards and flexed forward. During this procedure the fingers are employed in massage of the body. He claims that most cases will yield to this treatment. It is especially useful for nurses and obviates in the majority of cases any intra-uterine manipulation and consequent risk of sepsis. R. M. ALLAN.

## Annali di Ostetricia e Ginecologia.

*May*, 1914.

1. A case of solid ovarian teratoma (Sul teratoma solido dell' ovario). FALCO.
2. Researches on the ileo-cæcal-appendicular region in the fœtus and in the newly-born infant (Ricerche sulla regione ileo-cieco-appendicolare del feto e del neo-nato). VALTORTA.
3. *Contribution to the study of the colostrum cells (Contributo allo studio delle cellule del colostro). CATTANEO.

**Contribution to the study of the colostrum cells.** Cattaneo reviews different researches made from time to time on the origin, structure and function of the cells of the colostrum, and gives his own conclusions, after studying colostrum cells obtained from newly-born infants, and from women during menstruation, pregnancy, puerperium, also while suffering from cystic ovarian tumours. With the exception of cells obtained in one or two cases of macerated fœtus, he found that in all other cases the cells were structurally alike, consisting of a delicate protoplastic network, with numerous vacuoles filled by sudanophil granules, and having usually one nucleus but sometimes as many as six nuclei. Some investigators think the cells are derived from the glandular alveoli or from the large lymphocytes of the blood. Cattaneo is of opinion that the cells of the interstitial tissue are not only similar to but identical with the cells of the colostrum, and he inclines to the belief that the latter are derived from the former. This implies that the cells of the internal mammary secretion give rise to those of the external secretion.

J. H. F.

## Archivio Italiano di Ginecologia.

*May* 31, 1914.

1. Congress of the German Society of Surgery. Subject of discussion :— The treatment of malignant tumours by radium and by röntgen rays.
2. Congress of the German Society of Radiology. Subject of discussion :— Biologic action of röntgen rays on the normal animal and human tissues.
3. Action of röntgen rays on the ovaries. REIFFERSCHEID.
4. Biologic action of röntgen rays on the testicles. SIMMONDS.

*June* 30, 1914.

1. The resistance of the uterine cicatrix in extra-peritoneal Cæsarean section (Sulla resistenza della cicatrice uterina nel taglio Cesareo extra-peritoneale). DELLE CHIAJE.
2. Italian gynæcology (La ginecologia Italiana). BOSSI.

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## Results of the clinical investigations based on the methods of Abderhalden.

J. O. GAVRONSKY (*Lancet*, January 16, 1915) gives an account of six months' work on the above subject. He first discusses the value of the test from a specific point of view, and points out the value that Abderhalden's work has given, and will with further investigation give, to the medical profession. He then goes on to give details of his methods of carrying out investigations, especially pointing out any difference in technique to that prescribed by Abderhalden himself. Next a table gives the results of investigation in 121 cases, in nearly all of which both the dialysation and optical methods of obtaining the result are given, and in his conclusion he points out that at present the possibility of demonstrating specific ferments is not confirmed, but the following conclusions may be drawn :—

(1) The serum of pregnant patients contains proteo- and peptolytic ferments which are able to decompose any kind of coagulated albumin or peptone prepared therefrom.

(2) Whenever proteolytic ferments are found in the serum of patients with malignant tumours or other diseases, they have the property of acting in the same non-specific manner.

(3) The serum of perfectly normal individuals does not contain these ferments, at least in the great majority of cases. A negative result when we attempt to demonstrate proteolytic ferments in suspected cases of pregnancy or carcinoma speaks strongly against the existence of these states, and therefore may be of value in practice. J. M. W.

## A critical study of the basis of Abderhalden's serum reaction.

W. E. Bullock (*Lancet*, January 30, 1915). The chief object of the work done and shown in this paper was to test the reliability of the reaction as applied to the diagnosis of cancer. Most of the work done was on animals, and the results are shown in tables, 15 in all, and the conclusions the author comes to are :—

(1) It was found impossible to cause the production in rabbits of a ferment which digested coagulated egg-white by the injection subcutaneously, intraperitoneally or intravenously of raw egg-white.

(2) A minute quantity of amino acid is present in 10 cc. of blood serum of rabbits and dogs, and it was found (in rabbits) that after a bleeding these substances are increased in amount.

(3) An autolytic ferment is found in the blood serum of rabbits, dogs, and in human serum.

(4) The serum of the pregnant rabbit is unable to break down rabbit placenta and the serum of the pregnant bitch is unable to break down dog placenta. Human blood serum from the pregnant female and the healthy male incubated with human placenta produced, by chemical or physical action, amino acid.

(5) Rat blood serum ("normal" and "tumour") breaks down rat tumour. Guinea-pig serum ("normal" and "tumour") breaks down guinea-pig tumour and mouse tumour 63. The blood serum of the guinea-pig was not rendered more active in this property by a previous inoculation of the animal with mouse tumour 63.

The method devised by Abderhalden, even with the technical improvements described, is thus seen to be inadequate to distinguish normal from pregnant or cancerous sera. The fundamental experiments adduced by Abderhalden do not, on repetition, give the results stated by him, and a proteolytic ferment normally present in the serum of mammals acting on tissue substrates of varying lability, prepared in accordance with his directions, in all probability accounts for his results and their confirmation by others. J. M. W.

## The results of radical operative treatment of cancer of the uterus.

Thomas Wilson (*The Medical Press and Circular*, September 16, 1914). The author commences this paper with a review of ancient history. Amputation of the cervix gave a five years' freedom in less than 2 per cent. of the cases that applied for treatment, vaginal hysterectomy in 4 to 10 per cent. In regard to the abdominal radical operation the operability rate is 45 to 60 per cent., and the curability rate of all the cases seen from 15 to 20 per cent. Wertheim's operability rate in 450 cases was 46 per cent.; his primary mortality 19 per cent., and an absolute curability rate of 19 per cent. was reached.

In this country the operability rate is 30 to 40 per cent. and the total curability rate 10 per cent.

From 1896 to 1913 the author collected 596 cases of uterine cancer; of these 67 were of the corpus uteri. In December, 1913, 12 out of 50 cases seen up to 1909 were alive five or more years after the operation, giving a curability rate of 24 per cent. Out of 529 cases of carcinoma of the cervix 386 had been seen up to 1909. For vaginal hysterectomy the author shows a curability rate of $5\frac{1}{2}$ per cent., while for abdominal hysterectomy he shows a rate of 10 per cent.

G. L.

## The treatment of inoperable carcinoma of the uterus by application of heat.

J. F. Percy (*Brit. Med. Journ.*, Aug. 1, 1914) has attempted to bring into the range of practical therapeutics the results of recent experimental work on the vulnerability of cancer cells to heat. Clinically, it has often been noticed that cancerous growths tend to recede temporarily if the patient, from any cause, gets a temperature of 104° F. or more. Experimentally, many observers have made exact observations on the effect of heat on cancer cells *in vitro*. Thus, Jensen places the vulnerability of cancer cells at 116.6° F. for five minutes, and Percy quotes the results obtained by other observers in this experimental field.

As to the practical application of this knowledge, the problem is to apply heat to a cancerous growth in such a way as to entail the maximum of destruction to the cancer cells with the minimum danger to the normal connective tissue-cells. Percy mentions the various technical methods which have been tried, and goes on to describe and recommend his own method, which is especially applicable to inoperable carcinoma of the uterus. He uses an electric heating iron, which can be perfectly regulated by a rheostat when applied to the involved tissue. A low degree of heat is attained: the growth is not burnt and charred but merely becomes so hot that the hand of the surgeon, encased in a medium weight rubber glove cannot hold it. When this degree of heat is reached and maintained for twenty minutes, the cancer cells are absolutely killed, while the normal tissue-cells are not injured. Cancer is destroyed when the temperature in the mass is raised to 122°—131° F., while the vitality of normal tissues is not changed until the temperature exceeds 131°—140° F. General anæsthesia is necessary and the treatment may be repeated two or three times at intervals of a week or more. Percy gives no statistics of his cases; these he will leave for a future paper. He believes that a large number of cases, if not practically hopeless when first presenting themselves for treatment, will give approximately 50 per cent. remaining free from recurrence over five years.

## Pregnancy complicated by severe morbus cordis: two cases treated by hysterectomy under spinal anæsthesia.

J. Bright Banister (*Lancet*, Aug. 15, 1914). (1) A primigravida, four months' pregnant: severe breakdown of cardiac compensation, accompanied by pulmonary œdema. The uterus was emptied by vaginal metrotomy: Barker's heavy solution of stovaine was used to produce the spinal anæsthesia. The operation was easy and rapid and the patient bore it well, but died the next day from progression of the pulmonary œdema.

(2) A v-gravida, who had had attacks of failure of cardiac compensation with her last three pregnancies. She was first seen in the fifth month of her present pregnancy, with severe signs of cardiac failure. There was no cardiac murmur, and the cardiac condition seemed to be one of general myocardial degeneration. She improved for a time under general treatment, but a week before term her condition became very distressing. The author decided on Cæsarean section under spinal anæsthesia for the following reasons: (1) Cæsarean section was the quickest method of delivery and the one least likely to throw strain on the heart; (2) sterilization could be carried out; (3) a general anæsthetic was absolutely contraindicated as the case was one of general myocardial degeneration. The operation was completely successful both for mother and child.

## Vagitus uterinus.

BRODHEAD (*Amer. Journ. Obstet.*, June, 1914) stated at a recent meeting of the New York Academy of Medicine that a case of vagitus uterinus had been reported in the *New York Medical Journal*, October 2, 1913, by Telfair. At that time it was stated that until very recent years every paper on this subject had aroused a storm of criticism, sometimes ridicule. This criticism was not limited to the profession in general, the bitterest usually came from obstetricians of wide experience. These men were frank to say that they had never seen a case, and did not believe that anyone else ever had. At the close of his article Telfair stated that of forty-four reported cases more than one-half were operative deliveries; eleven being forceps, fifteen versions, and one replacement of arm and cord. The fœtal mortality was 10 per cent., many of the surviving children living only after prolonged efforts at resuscitation.

The history of Brodhead's case reported was as follows: Mrs. C., a vii-para, went into labour March 24, 1911, at 8 p.m. The first stage lasted ten hours, and the membranes were ruptured artificially. The second stage was prolonged and it was decided to apply forceps. The head was below the brim, the fœtal pulse was 140 to 150, and the patient's 128. The intern who was in charge of the case stated that the right hand was introduced to the left ear, and he was about to pass the left blade when he heard a distinct loud cry from the baby, the cry being heard also by the anæsthetist, by a woman in the same room, and by another woman who was in the adjoining room. The cry continued at intervals from that time until the head was extracted thirteen minutes later. Traction was continuous and the delivery was completed as soon as possible. The child had a good colour, was in good condition, and weighed ten pounds, ten ounces. To the list of published cases one other could be added which was reported by Marx to the New York Obstetrical Society, a full report of which was to be found in the *Transactions of the New York Obstetrical Society*, 1906–1907, page 257. Marx stated that he had heard such a cry once before in his experience. When asked to discuss this case of Marx's, an eminent obstetrician stated that in his opinion such a cry was impossible. This only bore out what Telfair had already stated, namely, the sincere doubt which had existed in the minds of men even of large experience, with reference to the possibility of a uterine cry. Both of the men who were in charge of the case reported were thoroughly reliable observers, and there was absolutely no doubt in his mind, Dr. Brodhead said, as to the correctness of the report in every detail. Malcolm McLane said that he had reported an authentic case. The fœtal head was well up in the uterus.

There was a suction and he was astounded to hear the child cry and this continued for several minutes. There was present a superstitious nurse who spent most of her time on her knees. He had seen many cases where the child cried in the vagina but he did not think they were worthy of reporting. In this instance the child was well up in the uterus. Telfair asked if this was an operative case. McLane replied that the patient was being prepared for operation when there was this suction of air into the uterus, which accounted for the cry. Telfair said that critics maintained that it was impossible to speak of what one heard. Some cases were explained by a vibrating fold of mucous membrane. Brodhead asked when this report appeared. McLane said the report appeared in the records of the *American Journal of Obstetrics*, probably sixteen years ago. A. D.

# REPORTS OF SOCIETIES.

## ROYAL ACADEMY OF MEDICINE IN IRELAND.

### SECTION OF OBSTETRICS.

President—M. J. GIBSON, M.D.
Sectional Secretary—GIBBON FITZGIBBON, M.D., F.R.C.P.I.

Meeting held on Friday, February 12, 1915, THE PRESIDENT in the Chair.

*Exhibits.*

MYOMATOUS UTERUS REMOVED DURING PARTURITION.

Sir WILLIAM SMYLY said this uterus was removed from a woman who had been in labour twenty hours. The labour was obstructed by a large fibro-myomatous tumour which occupied the pelvic cavity. It was an extra-peritoneal tumour, situated in the triangle bounded in front and below by the cervix and vaginal wall, behind by the rectum, and above by peritoneum; it was fixed in the pelvis. The walls of the uterus were enormously thickened, and the lower uterine segment was very much thinned out.

The patient was aged forty-five, and this was the sixth pregnancy. On the 5th of January last, at 2 p.m., the membranes ruptured, the local midwife was called in, and she sent for Dr. Murray, who, after consultation with Dr. Wallace, determined to bring her to Dublin from Roscrea, in the County Tipperary. He (Sir William) considered that Dr. Murray, who was in attendance, deserved the highest credit for his courage and humanity in bringing this patient, who had been many hours in obstructed labour, a long railway journey from Roscrea to Dublin. She arrived at the Rotunda Hospital at 5 a.m. When examined there it was found that the head was freely movable above the brim, but no fœtal heart could be heard. On vaginal examination the pelvis was found to be blocked by a large tumour, and the fœtal head could only be reached with difficulty. The child was dead. The patient had already been examined by three different people, and the case was therefore not certainly in an aseptic condition. There was not room to perforate, and extraction by version or by forceps was out of the question. It being impossible to push up the tumour, it was at first determined to wait to see what nature would do. Morphine and scopolamine were given. However, at 10 a.m. there was no alteration in the condition, and it became necessary to deliver. It was then decided to do Cæsarean section and to remove the uterus and tumour. Cervical Cæsarean section offered no advantage, so the classical operation was done, and the tumour and uterus were removed. The patient made a normal recovery.

RUPTURED HORN OF A TWO-HORNED UTERUS.

Sir WILLIAM SMYLY said this specimen was removed from a young married woman, who was four months pregnant. On the morning of the 20th of January last she was in perfect health, and had arranged with a

friend who was a trained nurse to call for her to go to Mass at eight o'clock; but just as the friend came in she felt what she described as if a knife had been thrust into her umbilicus, and then fainted. After a time she recovered, and fainted again, and spent the whole day going from one fainting fit to another until 4 p.m. Dr. Winder was then called in, and sent her to the Rotunda Hospital at about 6.30 p.m., so that she had been bleeding from 8 a.m. until 7 p.m., before operation. When admitted she was blanched and pulseless, and there was no doubt about the diagnosis of ruptured ectopic pregnancy. When the abdomen was opened a two-horned uterus was found. The fœtus had escaped into the abdominal cavity, and the placenta was extruding through the opening. The horn was removed, and the patient recovered.

Dr. Purefoy said he was fortunate in having seen both the cases brought forward by Sir William Smyly. They illustrate most forcibly the demands which may sometimes be made on the surgical skill and knowledge of the obstetrician. The thickening of the uterine wall was very observable, and he was not sure that it was only due to the uterine action which had for so many hours preceded the operation.

In the second case the collapse was such as to leave only the slenderest hope of the patient's recovery, and as the operation proceeded the patient was to all appearance moribund. The hypodermic injection of ether proved most helpful in rallying her. The urgent need for speedily concluding the operation furnished one very cogent reason for omitting what some of us regard as an important detail in such cases—viz., the removal of the free blood from the peritoneal cavity by flushing with hot saline; on this point, however, opinions vary. It is interesting to recall that in several cases of spontaneous uterine rupture in the early months, such as that recorded by Dr. McKinley in 1850, by Dr. Hooper, Dr. Harrison, and Dr. Scott, as well as one recorded by Dr. Collins, a former Master of the Rotunda Hospital, the lesion was situated in the fundus. No satisfactory explanation of this fact has yet been offered. The placenta is so rarely attached in this area, the action of the trophoblast cannot be accepted as a solution of the problem.

Dr. Spencer Sheill asked if very much difficulty was experienced in removing the tumour without separating the uterus from it first. He suggested that it might have been possible to push the tumour up. He was recently consulted by a patient who has a tumour about half as large again as the one shown, but not quite so fixed, and he was, therefore, anxious to know, if this case had been seen in the third month of pregnancy, what course would have been adopted. Would it be considered desirable to recommend, as he did in his own case, the removal of the tumour, or to advise waiting until labour occurred.

The President said he would like to know if hysterectomy had been done in the first case on account of risk of infection before the patient came into hospital. The case appeared to have been suitable for the operation of Cæsarean myomectomy; but, of course, if there was doubt about the management of the case before it came into hospital, it was wiser to remove the probably infected uterus.

In the second case the important point was the situation of the placental site; where the specimen had given way the wall was much thinner than anywhere else. It would be of interest to know what information the microscopical examination had given regarding the decidual reaction, and whether the thinning was due to the trophoblast.

Sir WILLIAM SMYLY, replying to the remarks, said no marked contraction ring was felt, but the lower uterine segment was very thin. He had not examined the posterior wall, but thought it was the same as the anterior one. He considered the point as to whether it was safer to leave or remove the blood of much importance; but thought that washing out the blood in a very bad case just made the difference between life and death. He had never before tried leaving it. He agreed with the President as to myomectomy being the ideal operation. The reasons why he did a hysterectomy in this case were given by the President himself, but in addition the distance from the fundus down to where the tumour was situated was very considerable, and he thought a myomectomy would have been difficult; but if the patient had been younger, and the uterus aseptic, he believed myomectomy would have been the ideal operation. Had he met with the woman earlier in pregnancy, and knew what was going to happen, he certainly would have advised enucleation; but, of course, the tumour would have been very small, and it might have been difficult to determine whether it was intra- or extra-peritoneal; so the necessity for operation might not have been evident.

Dr. ROWLETTE had microscopic sections made through the torn part, which showed that the wall was eroded by the chorionic trophoblast.

### PATHOLOGICAL REPORT OF BROAD LIGAMENT SPECIMENS.

THE PRESIDENT said that the microscopical examination of the large tumour which he had shown at the last meeting of the Section had proved it to be a fibro-myoma. The tumour weighed seven thousand and twenty grams. The more central portions of it exhibited some myxomatous degenerative changes.

The second specimen shown at the same meeting was a case of fibroid uterus with a large cyst. Complete examination showed the cyst to be parovarian.

### FATAL GASTRO-INTESTINAL HÆMORRHAGE IN THE NEW-BORN.

Dr. SPENCER SHEILL differentiated between ordinary melæna neonatorum and the very fatal type of which so little appears to be known regarding its pathology. Having alluded to what has been published regarding the causation and treatment, he proceeded to relate details of a case under his own care. The child, aged two days, passed and vomited so much blood as to be almost moribund. The treatment he adopted was the subcutaneous injection of horse serum—a treatment, so far as he was aware, hitherto untried in such a case. The result was rapid and successful, and the child did well and remained so.

Sir WILLIAM SMYLY said he had used horse serum with an infant some months old, and it certainly appeared to do some good, but the case did not terminate so satisfactorily as the one now reported. It was administered hypodermically and by the mouth. His case was not, however, a similar one to that of Dr. Sheill, but the treatment was the same. It was a case of purpura hæmorrhagica.

Dr. TIERNEY recalled three such cases. The first was rapidly fatal. In the second he he tried the gelatine prescription mentioned in Dr Sheill's paper, using commercial gelatine instead of Merck's gelatine. This was given by the mouth in drachm doses every hour, and the patient gradually got better. The third case was a milder one, and, with similar treatment to the second case, the result was quite good.

THE PRESIDENT said he remembered two cases such as Dr. Sheill had reported, but of a less severe type; both recovered without any special treatment. In a bad case he had no doubt the serum would be of the greatest benefit. He inquired as to Dr. Sheill's impressions regarding the injection of saline into a patient who was bleeding.

Dr. SPENCER SHEILL, replying to the remarks, said whether the result was due to the treatment or not he could not say. The patient might have got well in any event. He did not like to claim definite results from a single instance. The disease he looked upon as comparatively rare. He had seen a good many cases of melæna neonatorum which might be looked upon as the same disease, but in a lesser degree. He was interested in the use of horse serum in typhoid. He thought that the presumption was that it increased the coagulability of the blood by increasing leucocytosis. Saline injections were given to prevent collapse from the want of blood, and gelatine was given to prevent further loss; whether it was absolutely scientific to administer both together he could not say. The child had, he considered, reached the limit. The pulse could not be felt at the wrist, so he thought it would be safe to use saline injections to prevent the child from dying, in spite of the chance of raising the blood pressure. The same applied to adrenalin. The serum injected showed a definite result within two and a half hours. He had no experience of human serum; but he could find nothing in the literature to suggest that it had a better effect than the horse serum, and the latter was more readily obtained. As to an ounce of human serum being necessary, that might be so, but his case, he thought, tended to show that such an amount of horse serum was not required; he considered that the horse serum had more than an effect on the coagulability of the blood. It acted as a hormone. His case could hardly be considered parallel to Sir William Smyly's if the latter was one of purpura hæmorrhagica.

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## ROYAL ACADEMY OF MEDICINE IN IRELAND.

### SECTION OF OBSTETRICS.

President—M. J. GIBSON, M.D.
Sectional Secretary—GIBBON FITZGIBBON, M.D.

Meeting held Friday, March 12, 1915, THE PRESIDENT in the Chair.

*Exhibit.*

AN UNUSUAL DEGENERATION OF THE CERVIX.

Dr. ALFRED SMITH said that the patient, aged 60, the mother of sixteen children, consulted him on account of a profuse slimy discharge. The menopause came on ten years ago. She enjoyed good health up to August last, when she noticed a slimy discharge coming from her vagina. There was neither hæmorrhage nor pain nor offensive odour. On making a bimanual examination, the vaginal portion seemed to have disappeared, the margins being flush with the vaginal vault, the os being so dilated that the index and middle finger could easily be passed in. The impression conveyed was that there was no internal os, that the cavity of the uterus was greatly dilated; the mucous membrane felt like velvet pile. This slight palpation caused hæmorrhage. On curettage, large quantities of brain-like matter

came away, as in cancer. The pathologist reported non-malignant. A simple panhysterectomy was performed. The total length of the uterus was 12 cm., fundus 3.5 cm., cervix 8.5 cm., greatest width 6.7 cm. The fundus of the uterus is normal, but the cervical portion is greatly thickened. On section, this thickening is seen to be due to the transformation of the normal muscle wall into a spongy mass infiltrated with mucoid material; this mucoid material is directly continuous with a large amount of mucous in the cavity of the cervix. This change affects the whole contour of the cervix, though it is more marked in the anterior and left wall. The remains of the true cervical wall is represented by a thin layer of fibro-muscular tissue. No evidence of malignancy. The specimen is in the nature of a channelled mucous polypus, but is remarkable in that it engages more or less uniformly the whole of the cervical wall.

Dr. E. Hastings Tweedy said it seemed to be an adenomatous condition of the mucous membrane, something like a mucous polypus, spreading over the entire surface, and, when one considered it, if the disease that brought the mucous polypus into existence was present, why should it not attack the whole cervix?

Dr. R. J. Rowlette said he had never seen anything like this exhibit. It possessed remarkable similarities to the glandular structure found in mucous polypi. From the little he had seen of it he would be inclined to agree with Dr. Tweedy, but why a tumour should sometimes be so confined and at another time so diffuse as this, was a problem.

### A Note on the "Dublin Method" of Conducting the Third Stage of Labour.

Dr. T. P. C. Kirkpatrick investigated the claim put forward that the method of conducting the third stage of labour, known for so long as the "Dublin method," had originated in Dublin. He showed by extracts from the Midwifery of Fielding Ould, published in Dublin in 1742, that this method was not then taught by him. After Ould, the next work on Midwifery by a Dublin writer was that published by Foster in 1781; yet even in this work the "Dublin method" is not clearly described. In 1768, however, John Harvie published in London a short pamphlet, in which he gave a clear and exact description of the method. It seems probable, then, that Harvie was the first to describe the method, and that subsequently it was adopted as the teaching of the Dublin Lying-in Hospital. Though the Dublin School may not be able to claim the honour of having first described the method, yet that School deserves every credit for so early recognising its value and for so consistently teaching it.

Dr. Purefoy said he thought the idea of robbing the Rotunda Hospital of the credit of producing a practice which obstetricians all the world over admitted was a markedly safe practice might have been left to someone else. That Dr. Kirkpatrick had succeeded in the task he for one was very unwilling to admit. He was the happy possessor of Ould's book; he had not studied it with sufficient care to be aware of his views on the management of the third stage, but at any rate the Dublin School has been credited for a very long time with being the originators of this method of management of the third stage, and in Spiegelberg's Midwifery he alludes to it as the Dublin Method, and his allusion to it left no doubt on his (Dr. Purefoy's) mind that it was generally recognised as such. The fact that Dr. Harvey described the method did not at all prove (although he must be given full credit for having used it in his own practice) that it

originated in England. Whether Dr. Kirkpatrick had tapped all the sources of information on this point he did no know, but he could not help thinking that this practice had been known for a very long time, and in those early days they were not so keen to support their claims as the originators of many excellent practices in midwifery because it was considered that they were generally admitted. He hoped that he might obtain evidence that this method of treating the third stage was in general practice in Ireland very shortly after Sir Fielding Ould's book was published. He thought it should be possible to find that this was the practice, although not specially alluded to, because it was generally recognised. He was still unwilling to give up the practice of speaking of this as the Dublin method, and he considered it a pity that they should be deprived of the credit of what he believed to be the practice of the Dublin School for a very long time. Many of our most cherished and widely received beliefs and opinions are based on tradition, and ecclesiastical writers have often pointed out the danger of depending on *ex silentio* arguments.

Sir WILLIAM SMYLY said they should feel very much indebted to Dr. Kirkpatrick for his careful research into this question, and there was no doubt that the description published by Dr. Harvey was what was now generally known as the Dublin method; but he thought that in most of the discoveries in Medicine the credit was more often given to the person who popularised the method than to the person who first described it. The method appeared to be only mentioned by Dr. Harvey, and he did not even appear to attach much importance to it, as he placed two other methods before it in his book. Whereas in Dublin it was exclusively and systematically taught for generations. He mentioned that when Spiegelberg visited this country he wrote a report in which he said that the two things which impressed him most were the Dublin method of the delivery of the placenta and the use of chloroform in Edinburgh. He did not think Créde's method was the same as the Dublin method, as his method was much more active and designed to get rid of the placenta as soon as possible; and he advised that it should be expelled with the third pain. Sir William Smyly thought the very best method was the one referred to as being practised by primitive people—*i.e.*, sitting in the crouched position and rubbing the hypogastrium with the hand, and he suggested that the Dublin method was an adaptation of that. He added that after having tried different methods for the management of the third stage, he had come back to the Dublin method as the best.

Dr. TWEEDY said that all Dublin obstetricians had been accustomed to look upon Sir Fielding Ould as the founder of the Dublin method of dealing with the third stage of labour. The method is not described in Ould's book. This book was, however, written when the author was only 21 years of age, and before he had acquired any practical experience in obstetrics. He did not become Master of the Rotunda Hospital for sixteen years afterwards. It is, therefore, quite possible that the method described by Harvey originated with Ould, and he (Dr. Tweedy) thought they would be fully justified in believing in the tradition as to the origin of the method.

Professor SMITH said the late Sir Arthur Macan had asked him some years ago to go through the literature to ascertain the claims of Dublin to this method, but he could get nothing but tradition to support it. Sir Arthur Macan, although very much in favour of German methods and literature, was convinced that this method originated in Dublin. Harvey's book did not come under their notice at the time. He agreed with Dr.

Purefoy that the case was not proven. He pointed out that Crêde had found that expressing the placenta quickly after birth was followed by hæmorrhage, and in order to prevent this he recommended that at the tenth uterine contraction the placenta should be expressed. At the same time the practice which is known as the Dublin method of managing the third stage was carried on in Dublin by Sir Fielding Ould.

Dr. ASHE said he did not think it made very much difference whether the case was proven or not. He considered that when a method was taught in a place and the name of the place was attached to it, that place deserved the credit. This method was known throughout the world as the Dublin method.

Dr. KIRKPATRICK, in reply, said it was no pleasure to him to take away any credit from the Dublin School or from the Rotunda Hospital. The record of the Dublin School of Midwifery was one that any country might be proud of, and was, he believed, one of the best records of any department of Irish Medicine. Historical accuracy was, however, a thing greatly to be desired, and the Rotunda Hospital does not need to base its claims to greatness on a suppression of the truth. Many of those who have written on this subject appear never to have seen Harvie's book. McClintock mentioned the book, but said he had never seen a copy of it. Jellett makes no mention of it at all. Had this method of conducting the third stage of labour been the teaching of the Rotunda Hospital when Ould was Master, from 1759 to 1766, it would almost certainly have been described by Foster, who was Assistant to Ould's successor in the Mastership—William Collum. Foster, however, does not describe the method.

### ALEXANDER-ADAMS' OPERATION AND ITS RESULTS.

Dr. D. G. MADILL reported the after-results of cases, and described the method of doing the operation with a single incision.

Professor SMITH said it was pleasant to hear good words about an old academic operation. Dr. Madill had brought forward a record of 250 cases done at the Rotunda Hospital in four years, which showed there was a good number of suitable cases for the operation. His own experience was that the type of case suitable for Alexander's operation hardly required an operation at all. In the type of cases suitable for this procedure it was found necessary to either introduce a pessary or to do an operation. Patients who came into St. Vincent's Hospital complaining of backward displacement, menorrhagia and menstrual pain were first examined under an anæsthetic. If the uterus was found to be mobile a simple method of replacement was adopted by applying the weight of the ordinary Rotunda douche, which usually brought the uterus through the Bozeman's catheter into position. The patient was then put back to bed and examined on the third day; the uterus was usually found to remain in position. In that type of case the Alexander operation was usually performed. That Alexander's operation gave good results in a certain limited class of cases he agreed, but he thought it would not do so if the uterus was enlarged. If a case was one for operative interference an operation should be done with which one could be satisfied that he had done the best for the patient, and not one that was doubtful in its results.

Dr. HASTINGS TWEEDY said he considered that few would disagree with Dr. Madill if once his premises were allowed; but neither Dr. Madill nor anybody else could say that he had not been mistaken in bi-manual examinations, and it was the possibility of these mistakes which robbed

Alexander's operation of its value. He could not agree with Professor Smith that Alexander's operation was easy. He looked upon it as easy for the expert, but difficult for the novice. Personally, he favoured the operation of ventro-suspension, but his results from vaginal suspension have also been good. Thus he had received replies from nine patients on whom this operation had been performed. All expressed themselves as having been improved, and four had become pregnant and delivered themselves normally. He thought Dr. Madill had curtailed the operation greatly when he suggested that it should not be done for sterility.

Dr. GIBBON FITZGIBBON thought that any operation for the cure of retroversion of the uterus would produce as good results as the statistics brought forward showed. He agreed with Dr. Tweedy that there were no complications after ventral suspension. He had followed up a good many of his own cases, and had never found any trouble arising afterwards in pregnancy or parturition. The number of cases which he had come across suitable for Alexander's operation was exceedingly small, and if sterility was to be excluded they would have been further reduced. Out of seven cases in which he had done vaginal suspension during the child-bearing period, one of them afterwards had twins and two others had single pregnancies, without any complications. He considered that a number of cases of retroverted mobile uterus do not cause any symptoms unless there is trouble in the tubes, in which case ventral suspension enables an attempt to be made to correct the cause of the sterility. It was astonishing the number of times one came across adhesions of the tubes in cases with a mobile retroverted uterus with practically no thickening of the tubes which would be palpable by bi-manual examination.

Dr. PUREFOY said he felt indebted to Dr. Madill for the well-reasoned statement of the case put forward for the Alexander-Adams' operation, and he was certain the paper would be considered an important contribution to the literature of the subject. Dr. Madill had pointed out to them the points of chief importance in the successful performance of the operation. He had pointed out the dangers to avoid and the drawbacks to the procedure. Dr. Madill had stated that it was a safe and justifiable procedure in a very considerable portion of the cases met with, but wisely abstained from comparing it with the results by other methods. He (Dr. Purefoy) recollected that during his Mastership at the Rotunda Hospital this operation had not come into general use there, and he was against it because a woman came into the hospital and said that that was the third miscarriage she had since she had this operation performed by the inventor in Liverpool. He had on several occasions since seen the operation performed in the Rotunda Hospital, and he was very pleased with the facility with which it was done. He confessed that he had a leaning towards the operation of ventral suspension, but he thought Dr. Madill's statement was a powerful one for the operation in the cases he had indicated.

Dr. SOLOMONS said it seemed to him that there were certain definite cases where the Alexander operation was very suitable. In cases of prolapse of the uterus, in addition to plastic work by the vagina, he considered the operation very useful. In cases in which the retroversion occurs *post-partum*, and where palliative treatment fails to produce a cure, an Alexander-Adams' operation was most suitable. He suggested if either Alexander's operation or ventral suspension were properly performed there would be very little difference in the results. He considered that one of the prime arguments for an operation for the cure of a simple retroversion

consisted in the neurotic symptoms which often followed the insertion of a pessary after the operation. He found that the Alexander-Adams' operation was effective in producing a cure without inserting a pessary afterwards.

The PRESIDENT said that in dealing with mobile retrodisplacement three classes of cases generally come under consideration. Firstly, the unmarried woman with uncomplicated retro-displacement. These patients have no symptoms which can be attributed to displacement, and correction of the displacement is not necessary. Secondly, the married woman who is bearing children and is suffering, as a considerable number do, from retro-displacement complicated with descent. The uterine descent in these cases is associated with definite discomfort. Examination under anæsthesia and the absence of history of infection enables adnexal trouble to be excluded, and in these cases vaginal repair with correction of the displacement by the Alexander-Adams' operation give excellent results. Thirdly, the married woman who is sterile. In those cases if an operation is performed for the cure of displacement, it ought to be one which allows of examination of the tubes. If a transverse incision be made the tubes may be examined and treated and the Alexander-Adams' operation performed without difficulty. He prefers the Alexander-Adams' operation to ventral suspension because relapse is not so liable after parturition, and the position obtained is more normal.

Dr. MADILL, replying, said he had seen Sir William Smyly doing a modified Gilliam's operation that morning, and it appeared to have most of the advantages of the Alexander, and in addition there was the extra advantage of seeing the inside of the abdomen. He had no experience of Professor Smith's method of bringing the uterus up, but what was done in the Rotunda Hospital was if the uterus remained forward when brought into position it was taken for granted that there were no adhesions. Two anæsthetics were not necessary, as examination could be carried out under an anæsthetic, and the operation decided on could be gone on with. He admitted that a weak point was that one could not be absolutely certain, but he was glad to have the support of the President that one could be fairly certain after examination under an anæsthetic. He admitted that a certain amount of practice was necessary to become expert at the operation, but this could be said of all operations. He had nothing to urge against ventral suspension, except to doubt that the uterus remained in position after confinement. He remembered more than one case in which the uterus retroverted again after suspension. If there was no recurrence he was certain it was a better operation than the Alexander-Adams'. An important point, he considered, was that nearly all his patients expressed themselves as satisfied, but none of them were done for sterility. The results of the Alexander operation were good after confinement, and that was a most important point. There were, he thought, quite a large number of cases apart from sterility in which the operation was suitable. There were, he knew, a number of cases in which there were no symptoms, but all the cases recorded by him had symptoms. The pessary was put in for two or three weeks only, and he thought this might be done with advantage after all operations for retro-displacement.

# REVIEW.

A TEXT BOOK FOR MIDWIVES. By John S. Fairbairn, M.A., B.M., B.Ch. (Oxon), F.R.C.P., F.R.C.S. Henry Froude, Hodder and Stoughton, 1914. Price 10/6 net.

THE publication of this book is a sign of the times that the ill-educated rule of thumb midwife is disappearing and is being replaced by the modern well-trained nurse with a thirst for knowledge. To such this book should be invaluable both as a text-book during her probationary period and later as a ready help in times of trouble when faced with a case she may not understand. And, perhaps most of all, those midwives instructing pupils, whose own knowledge of theory and practice of obstetrics may be a little out of date, will find the teaching they impart will be of much greater value after perusal of this book. The author considers, and we think rightly, that the midwife should know how to deal with the complications of midwifery in the absence of medical assistance, but by incorporating the rules of the C.M.B. in the text he emphasises the fact that the midwife is forbidden to deal with such complications if assistance can be obtained.

The book opens with an introduction on the elements of general anatomy, physiology and bacteriology, roughly comparable to the lectures in these subjects which are given to nurses in the training schools of the general hospitals, but which from lack of time are perforce omitted in the training of pupil midwives. These subjects are dealt with in clear and, as far as possible, non-technical language, and if once the pupil has grasped them she will realise on what a sure foundation her future practice is founded.

The chapters on the practice of midwifery are systematically arranged, and the teaching conveyed in them sound and to the point. The diagrams and illustrations are numerous and everywhere good, so much so as almost to refute the author's advice that nothing can make up for the actual study of museum specimens and that such subjects as the mechanism of labour can only be learnt by actual practice with the pelvis and fœtal skull. The chapters on surgical cleanliness, the management of the birth of the forecoming head and of the third stage of labour may be taken as types of the way in which, throughout the book, theory and practice are blended together, and the pupil trained to think in a logical and consecutive way.

In dealing with the accidents and emergencies of obstetrics the author seems to have two objects in view: firstly, that in dealing with such conditions as post-partum hæmorrhages, eclamptic convulsions, etc., the midwife must realise that she will probably be unaided and must apply appropriate treatment at once and on her own authority, but, on the other hand, that in such conditions as ante-partum hæmorrhage, prolonged and obstructed labour, her duty consists in early diagnosis and recognition of the fact that the treatment is outside her province. Nevertheless the modern views of the management of such cases is clearly stated so that the midwife should be able to deal with them if assistance is unobtainable. Sound advice is given as to the nursing of the puerperal woman and the

management of the infant, and all pupils would do well to read, mark, learn and inwardly digest the eminently practical instructions given in the chapters on the midwife's duties in the preparation for and assistance at operative delivery. By so doing they will render themselves more than commonly useful.

Those pupils who have had no general nursing experience will find the glossary which completes the book of great assistance to them.

We feel that in the preparation of this book the author started on an ambitious task, and we are glad to be able to congratulate him on the very satisfactory result of his labour.

J. A. W.